



# **MULTIPLE CHOICE QUESTIONS**

## **GUIDE**

### **CBT EXAMS**

#### **FOR**

#### **NMC**

## TABLE OF CONTENT QUESTIONS

|                                            |      |
|--------------------------------------------|------|
| 1. NMC CODES AND ROLES                     | 1    |
| 2. ACTS AND REGULATIONS                    | 18   |
| 3. STUDENTS AND TRAINING                   | 29   |
| 4. DELEGATION                              | 47   |
| 5. ADVOCACY                                | 56   |
| 6. MANAGEMENT, LEADERSHIP, DECISION MAKING | 63   |
| 7. WOUNDS                                  | 178  |
| 8. URINE                                   | 221  |
| 9. HEART AND VEINS (CONDITIONS)            | 231  |
| 10. DIABETES                               | 276  |
| 11. SPECIMENS AND COLLECTION               | 289  |
| 12. ELDERLY                                | 301  |
| 13. CRUTCHES AND FRAMES                    | 336  |
| 14. BONES AND MUSCLES                      | 357  |
| 15. NUTRITION                              | 373  |
| 16. LUNG, OXYGEN AND LUNGS                 | 447  |
| 17. CONSENT AND THEATRE                    | 497  |
| 18. COMMUNICATION                          | 548  |
| 19. PREGNANCY                              | 625  |
| 20. THEORIES                               | 638  |
| 21. CLOSTRIDIUM DIFFICILE                  | 645  |
| 22. INFECTION                              | 654  |
| 23. SHOCK                                  | 689  |
| 24. CHILDREN                               | 705  |
| 25. BLOOD TRANSFUSIONS                     | 722  |
| 26. NURSING CARE PLANS                     | 728  |
| 27. MEDICATION                             | 795  |
| 28. PSYCHIATRY                             | 910  |
| 29. MEDICAL CONDITIONS                     | 933  |
| 30. DEATH AND DYING                        | 1033 |

### 1. What is the role of the NMC?

- a) To represent or campaign on behalf of nurses and midwives
- b) To regulate hospital or other healthcare settings in the UK
- c) To regulate health care assistance
- d) To regulate nurses and midwives in the UK to protect the public

### 2. What is the purpose of The NMC Code?

- a) It outlines specific tasks or clinical procedures
- b) It ascertains in detail a nurse's or midwife's clinical expertise
- c) It is a tool for educating prospective nurses and midwives

**3. All are purposes of NMC except:**

- a) NMC's role is to regulate nurses and midwives in England, Wales, Scotland and Northern Ireland.
- b) It sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.
- c) It makes sure that nurses and midwives keep their skills and knowledge up to date and uphold its professional standards.
- d) It is responsible for regulating hospitals or other healthcare settings.

**4. The UK regulator for nursing & midwifery professions within the UK with a started aim to protect the health & well-being of the public is:**

- a) GMC
- b) NMC
- c) BMC
- d) WHC

**5. Which of the following agency set the standards of education, training and conduct and performance for nurses and midwives in the UK?**

- a) NMC
- b) DH
- c) CQC
- d) RCN

**6. What do you mean by code of ethics?**

- A) Legal activities of a registered nurse who work in the UK
- B) Legislative body to control nurses

**7. The Code contains the professional standards that registered nurses and midwives must uphold. UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles; such as leadership, education or research.**

**What 4 Key areas does the code cover:**

- a) Prioritise people, practise effectively, preserve safety, promote professionalism and trust
- b) Prioritise people, practise safely, preserve dignity, promote professionalism and trust
- c) Prioritise care, practise effectively, preserve security, promote professionalism and trust

- d) Prioritise care, practise safely, preserve security, promote kindness and trust
8. **NMC requires in the UK how many units of continuing education units a nurse should have in 3 years?**
- a) 35 Units
  - b) 45 Units
  - c) 55 Units
  - d) 65 Units
9. **The code is the foundation of**
- a) Dress code
  - b) Personal document
  - c) Good nursing & midwifery practice & a key tool in safeguarding the health & wellbeing of the public
  - d) Hospital administration
10. **According to NMC Standards code and conduct, a registered nurse is EXCLUDED from legal action in which one of these?**
- a) Fixed penalty for speeding
  - b) Possessing stock medications
  - c) Convicted for fraud
  - d) Convicted for theft
11. **The NMC Code expects nurse to safeguarding the health and wellbeing of public through the use of best available evidence in practice. Which of the following nursing actions will ensure this?**
- a) using isopropyl alcohol 70% to wipe skin prior to cannulation
  - b) suggesting healthcare products or services that are still trialled
  - c) ensure that the use of complementary or alternative therapies is safe and in the best interest of those in your care
  - d) all
12. **Among the following values incorporated in NMC's 6 C's, which is not included?**
- a) Care
  - b) Courage
  - c) Confidentiality
  - d) Communication
13. **A nurse delegates duty to a health assistant, what NMC standard she should keep in mind while doing this?**
- a) She transfers the accountability to care assistant
  - b) RN is accountable for care assistant's actions

- c) No need to assess the competency, as the care assistant is expert in her care area
  - d) Healthcare assistant is accountable to only her senior
14. Which of the following is NOT one of the six fundamental values for nursing, midwifery and care staff set out in compassion in Practice Nursing, Midwifery & care staff?
- a) Care
  - b) **Consideration**
  - c) Communication
  - d) Compassion
15. According to law in England, UK when you faced with a situation of emergency what is your action?
- a) Should not assist when it is outside of work environment
  - b) Law insists you to stop and assist
  - c) **You are not obliged in any way but as a professional duty advises you to stop and assist**
  - d) Do not involve in the situation
16. According to NMC Standards code and conduct, a registered nurse is EXCLUDED from legal action in which one of these?
- a) **Fixed penalty for speeding**
  - b) Possessing stock medications
  - c) Convicted for fraud
  - d) Convicted for theft
17. The code is the foundation of
- a) Dress code
  - b) Personal document
  - c) **Good nursing & midwifery practice & a key tool in safeguarding the health & wellbeing of the public**
  - d) Hospital administration
18. A patient has been assessed as lacking capacity to make their own decisions, what government legislation or act should be referred to:
- a) Health and Social Care Act (2012)
  - b) **Mental capacity Act (2005)**
  - c) Carers (Equal opportunities) Act (2004)
  - d) All of the above
19. Under the Carers (Equal opportunities) Act (2004) what are carers entitled to?

- a) Their own assessment
- b) Financial support
- c) Respite care
- d) All of the above

**20. How many steps to discharge planning were identified by the Department of Health (DH 2010)?**

- a) 5 steps
- b) 8 steps
- c) 10 steps
- d) 12 steps

**21. The single assessment process was introduced as part of the National Service Framework for Older People (DH 2001) in order to improve care for this groups of patients.**

- a) True
- b) False

**22. Under the Carers (Equal opportunities) Act (2004) what are carers entitled to?**

- a) Their own assessment
- b) Financial support
- c) Respite care
- d) All of the above

**23. Which law provides communication aid to patient with disability?**

- a) Communication Act
- b) Equality Act
- c) Mental Capacity Act
- d) Children and Family Act

**24. Hearing aid provide to client comes under which act?**

- a) communication act
- b) mental capacity act
- c) children and family act.
- d) Equality Act

**25. Mental Capacity Act 2005 explores which of the following concepts:**

- a) Mental capacity, advance treatment decisions, and act's code of practice
- b) Mental capacity, independent mental capacity advocates, and the act's code of practice

- c) Mental capacity, advance treatment decisions, independent mental capacity advocates, and the act's code of practice
- d) Mental capacity and the possible ethical and legal dilemmas in its interpretation.

**26. An enquiry was launched involving death of one of your patients. The police visited your unit to investigate. When interviewed, which of the following framework will best help assist the investigation?**

- a) Data Protection Act 2005 
- b) Storage of Records Policy
- c) Consent policy
- d) Confidentiality guidelines

**27. Patient asking for LAMA, the medical team has concern about the mental capacity of the patient, what decision should be made?**

- a) call the police
- b) call the security
- c) let the patient go
- d) encourage the patient to wait by telling the need for treatment

**28. You are in a registered nurse in a community giving health education to a patient and you notice that the student nurse is using his cell phone to text, what should you do?**

- a) Tell the student to leave and emphasize what a disappointment she is
- b) Report the student to his Instructor after duty
- c) Politely signal the student and encourage him by actively including him in the discussion

**29. A person supervising a nursing student in the clinical area is called as:**

- a) mentor
- b) preceptor
- c) interceptor
- d) supervisor

**30. Training of student nurses is the responsibility of:**

- a) Ward in charge
- b) Senior nurses
- c) Team leaders
- d) All RNS

**31. A community health nurse, with second year nursing students is collecting history in a home. Nurse notices that a student is not at all interested in what is going around and she is chatting in her phone. Ideal response?**

- a) Ask the student to leave the group
- b) Warn her in public that such behaviours are not accepted
- c) Inform to the principal
- d) **Talk to her in private and make her aware that such behaviours could actually belittle the profession**

**32. In supervising a student nurse perform a drug rounds, the NMC expects you to do the following at all times:**

- a) **supervise the entire procedure and the sign the chart**
- b) allow student to give drugs and sign the chart at the end of shift
- c) delegate the supervision of the student to a senior nursing assistant and ask for feedback
- d) allow the student to observe but not signing on the chart

**33. A nurse preceptor is working with a new nurse and notes that the new nurse is reluctant to delegate tasks to members of the care team. The nurse preceptor recognizes that this reluctance most likely is due to**

- a) Role modelling behaviours of the preceptor
- b) **The philosophy of the new nurse's school of nursing**
- c) The orientation provided to the new nurse
- d) **Lack of trust in the team members**

**34. Being a student, observe the insertion of an ICD in the clinical setting. This is**

- a) **Formal learning**
- b) **Informal learning** 

**35. When you tell a 3rd year student under your care to dispense medication to your patient what will you assess?**

- a) Whether s/he is able to give medicine
- b) Whether s/he is under your same employment
- c) **His/her competence and skills**
- d) Supervise directly

**36. You are mentoring a 3rd year student nurse, the student request that she want to assist a procedure with tissue viability nurse, how can you deal with this situation**

- a) Tell her it is not possible
- b) **Tell her it is possible if you provide direct supervision**
- c) Call to the college and ask whether it is possible for a 3rd student to assist the procedure
- d) Allow her as this is the part of her learning

**37. A registered nurse is a preceptor for a new nursing graduate and is describing critical paths and variance analysis to the new nursing graduate. The registered nurse instructs the new nursing graduate that a variance analysis is performed on all clients:**

- a) **Continuously**
- b) daily during hospitalization
- c) every third day of hospitalization
- d) every other day of hospitalization

**38. you have assigned a new student to an experienced health care assistant to gain some knowledge in delivering patient care. The student nurse tells you that the HCA has pushed the client back to the chair when she was trying to stand up. What is your action**

- a) **As soon as possible after an event has happened (to provide current (up to date) information about the care and condition of the patient or client)**
- b) Every hour
- c) When there are significant changes to the patient's condition
- d) At the end of the shift

**39. In supervising a student nurse perform a drug rounds, the NMC expects you to do the following at all times:**

- a) **supervise the entire procedure and the sign the chart** 
- b) **allow student to give drugs and sign the chart at the end of shift**
- c) delegate the supervision of the student to a senior nursing assistant and ask for feedback
- d) allow the student to observe but not signing on the chart

**40. Who is responsible for the overall assessment of the student's fitness to practice and documentation of initial, midterm and final assessments in the Ongoing Achievement Record (OAR)?**

- a) **The mentor**
- b) The charge nurse/manager
- c) Any registered nurse on same part of the register

**41. What is the minimum length of time that a student must be supervised (directly/indirectly) by the mentor on placement?**

- a) **40%**
- b) 60%
- c) Not specified, but as much as possible
- d) Depends on the student capabilities

**42. Which student require a SOM?**

- a) **All consolidation students who started an NMC approved undergraduate programme which commenced after September 2007.**

- b) Learners undertaking conversion courses
  - c) Students on their final placement in 2<sup>nd</sup> year
  - d) Nurses/midwives undertaking Mentorship Preparation
  - e) All midwifery pre-registration students throughout training
  - f) Nurses/midwives undertaking SOM Preparation.
43. **A nurse educator is providing in-service education to the nursing staff regarding transcultural nursing care. A staff member asks the nurse educator to describe the concept of acculturation. The most appropriate response in which of the following?**
- a) It is subjective perspective of the person's heritage and sense of belonging to a group
  - b) It is a group of individuals in a society that is culturally distinct and has a unique identity
  - c) It is a process of learning, a different culture to adapt to a new or change in environment
  - d) It is a group that share some of the characteristics of the larger population group of which it is a part
44. **You are the nurse in charge of the unit and you are accompanied by 4<sup>th</sup> year nursing students.**
- a) Allow students to give meds
  - b) Assess competence of student
  - c) Get consent of patient
  - d) Have direct supervision
45. **You are a registered nurse in a community giving health education to a patient and you notice that the student nurse is using his cell phone to text, what should you do?**
- a) Tell the student to leave and emphasize what a disappointment she is
  - b) Report the student to his Instructor after duty
  - c) Politely signal the student and encourage him by actively including him in the discussion
46. **When doing your drug round at midday, you have noticed one of your patient coughing more frequently whilst being assisted by a nursing student at mealtime. What is your initial action at this situation?**
- a) tell the student to feed the patient slowly to help stop coughing
  - b) ask the student to completely stop feeding
  - c) ask student to allow patient some sips of water to stop coughing
  - d) ask student to stop feeding and assess patients swallowing
47. **To whom should you delegate a task?**
- a) Someone who you trust

- b) Someone who is competent
- c) Someone who you work with regularly
- d) All of the above

48. A nurse delegates duty to a health assistant, what NMC standard she should keep in mind while doing this?

- a) She transfers the accountability to care assistant
- b) RN is accountable for care assistant's actions
- c) No need to assess the competency, as the care assistant is expert in her care area
- d) Healthcare assistant is accountable to only her senior

49. Which of the following is an important principle of delegation?

- a) No transfer of authority exists when delegating
- b) Delegation is the same as work allocation
- c) Responsibility is not transferred with delegation
- d) When delegating, you must transfer authority 

50. A staff nurse has delegated the ambulating of a new post-op patient to a new staff nurse. Which of the following situations exhibits the final stage in the process of delegation?

- a) Having the new nurse tell the physician the task has been completed.
- b) Supervising the performance of the new nurse
- c) Telling the unit manager, the task has been completed
- d) Documenting that the task has been completed.

51. Which of the following is a specific benefit to an organization when delegation is carried out effectively?

- a) Delegates gain new skills facilitating upward mobility
- b) The client feels more of their needs are met
- c) Managers devote more time to tasks that cannot be delegated
- d) The organization benefits by achieving its goals more efficiently

52. A nurse delegates duty to a health assistant. What NMC standard she should keep in mind while doing this?

- a) She transfers the accountability to care assistant
- b) RN is accountable for care assistant's actions
- c) No need to assess the competency, as the care assistant is expert in her care area

53. A staff nurse has delegated the ambulating of a new post-op patient to a new staff nurse. Which of the following situations exhibits the final stage in the process of delegation?

- a) Having the new nurse tell the physician the task has been completed
- b) **Supervising the performance of the new nurse**
- c) Telling the unit manager, the task has been completed
- d) **Documenting that the task has been completed.**

**54. Which of the following is a specific benefit to an organization when delegation is carried out effectively?**

- a) Delegates gain new skills facilitating upward mobility
- b) The client feels more of their needs are met
- c) Managers devote more time to tasks that cannot be delegated
- d) **The organization benefits by achieving its goals more efficiently**

**55. The measurement and documentation of vital signs is expected for clients in a long-term facility. Which staff type would it be a priority to delegate these tasks to?**

- a) Practical Nurse
- b) **Registered Nurse**
- c) **Nursing assistant**
- d) Volunteer

**56. Independent Advocacy is:**

- a) Providing general advice
- b) Making decisions for someone
- c) Care and support work
- d) Agreeing with everything a person says and doing anything a person asks you to do
- e) **None of the above \***

**57. What is meant by an advocate?**

- a) Someone who develops opportunities for the patient
- b) Someone who has the same beliefs as the patient
- c) **Someone who does something on behalf of the patient**
- d) Someone who has the same values as the patient.

**58. A Nurse demonstrates patient advocacy by becoming involved in which of the following activities?**

- a) **Taking a public stand on quality issues and educating the public on "public interest" issues**
- b) Teaching in a school of nursing to help decrease the nursing shortage
- c) Engaging in nursing research to justify nursing care delivery
- d) Supporting the status quo when changes are pending

**59. In the role of patient advocate, the nurse would do which of the following?**

- a) Emphasize the need for cost-containment measures when making health care decisions
- b) Override a patient's decision when the patient refuses the recommended treatment
- c) Support a patient's decision, even if it is not the decision desired by the nurse
- d) Foster patient dependence on health care providers for decision making

60. What is Advocacy according to NHS Trust?

- a) It is taking action to help people say what they want, secure their rights, represent their interests and obtain the services they need.
- b) This is the divulging or provision of access to data
- c) It is the response to the suffering of others that motivates a desire to help
- d) It is a set of rules or a promise that limits access or places restrictions on certain types of information.

61. A nurse is caring for a patient with end-stage lung disease. The patient wants to go home on oxygen and be comfortable. The family wants the patient to have a new surgical procedure. The nurse explains the risk and benefits of the surgery to the family and discusses the patient's wishes with the family. The nurse is acting as the patient's:

- a) Educator
- b) Advocate
- c) Care giver
- d) Case manager

62. A nurse demonstrates patient advocacy by becoming involved in which of the following activities?

- a) Taking a public stand and quality issues and educating the public on "public interest" issues.
- b) Teaching in school of nursing to help decrease the nursing shortage
- c) Engaging in nursing research to justify nursing care delivery
- d) Supporting the status quo when changes are pending

63. Which of the following is NOT one of the six fundamental values for nursing, midwifery and care staff set out in compassion in Practice Nursing, Midwifery & care staff?

- a) Care
- b) Consideration
- c) Communication
- d) Compassion

64. A client experiences an episode of pulmonary oedema because the nurse forgot to administer the morning dose of furosemide (Lasix). Which legal element can the nurse be charged with?

- a) Assault
- b) Slander
- c) Negligence
- d) Tort

65. The client is being involuntary committed to the psychiatric unit after threatening to kill his spouse and children. The involuntary commitment is an example of what bioethical principle?

- a) Fidelity
- b) Veracity
- c) Autonomy
- d) Beneficence

66. What is accountability?

- a) Ethical and moral obligations permeating the nursing profession
- b) To be answerable to oneself and others for one's own actions."
- c) A systematic approach to maintaining and improving the quality of patient care within a health system (NHS).
- d) The process of applying knowledge and expertise to a clinical situation to develop a solution

67. According to the nursing code of ethics, the nurse's first allegiance is to the:

- a) Client and client's family
- b) Client only
- c) Healthcare organization
- d) Physician

68. Which option best illustrates a positive outcome for managed care?

- a) Involvement in the political process.
- b) Reshaping current policy.
- c) Cost-benefit analysis.
- d) Increase in preventive services

69. While at outside setup what care will you give as a Nurse if you are exposed to a situation?

- a) Provide care which is at expected level
- b) Above what is expected
- c) Ignoring the situation
- d) Keeping up to professional standards

70. As a nurse, the people in your care must be able to trust you with their health and well being. In order to justify that trust, you must not:

- a) work with others to protect and promote the health and wellbeing of those in your care
- b) **provide a high standard of practice and care when required**
- c) always act lawfully, whether those laws relate to your professional practice or personal life
- d) be personally accountable for actions and omissions in your practice

**71. Describe the primary focus of a manager in a knowledge work environment.**

- a) **Developing the most effective teams**
- b) Taking risks.
- c) Routine work
- d) Understanding the history of the organization.

**72. In using social media like Facebook, how will you best adhere to your Code of Conduct as a nurse? (CHOOSE 2 ANSWERS)**

- a) **Never have relationship with previous patient**
- b) **Never post pictures concerning your practice**
- c) Never tell you are a nurse
- d) Always rely SOLELY in your FBs privacy setting

**73. Which strategy could the nurse use to avoid disparity in health care delivery?**

- a) **Recognize the cultural issue related to patient care**
- b) Request more health plan options
- c) Care for more patients even if quality suffers
- d) Campaign for fixed nurse patient ratios

**74. In an emergency department doctor asked you to do the procedure of cannulation and left the ward. You haven't done it before. What would you do?**

- a) **Don't do it as you are not competent or trained for that & write incident report & inform the supervisor**
- b) What is the purpose of clinical audit?
- c) Do it
- d) Ask your colleague to do it
- e) Complain to the supervisor that doctor left you in middle of the procedure

**75. NMC defines record keeping as all of the following except:**

- a) **Helping to improve advocacy**
- b) Showing how decisions related to patient care were made
- c) Supporting effective clinical judgements and decisions
- d) Helping in identifying risks, and enabling early detection of complications

**76. When do we need to document?**

- a) As soon as possible after an event has happened to provide current up to date information about the care and condition of the patient or client
- b) Every hour
- c) When there are significant changes to the patient's condition
- d) At the end of the shift

**77. All should be seen in a good documentation except:**

- a) legible handwriting
- b) Name and signature, position, date and time
- c) Abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- d) A correct, consistent, and factual data

**78. A nurse documented on the wrong chart. What should the nurse do?**

- a) Immediately inform the nurse in charge and tell her to cross it all off.
- b) Throw away the page
- c) Write line above the writing; put your name, job title, date, and time.
- d) Ignore the incident.

**79. Information can be disclosed in all cases except:**

- a) When effectively anonymized.
- b) When the information is required by law or under a court order.
- c) In identifiable form, when it is required for a specific purpose, with the individual's written consent or with support under the Health Service
- d) In Child Protection proceedings if it is considered that the information required is in the public or child's interest

**80. Adequate record keeping for a medical device should provide evidence of:**

- a) A unique identifier for the device, where appropriate
- b) A full history, including date of purchase and where appropriate when it was put into use, deployed or installed
- c) Any specific legal requirements and whether these have been met
- d) Proper installation and where it was deployed
- e) Schedule and details of maintenance and repairs
- f) The end-of-life date, if specified
- g) All of the above

**81. A registered nurse had a very busy day as her patient was sick, got intubated & had other life saving procedures. She documented all the events & by the end of the shift recognized that she had documented in other patient's record. What is best response of the nurse?**

- a) She should continue documenting in the same file as the medical document cannot be corrected
- b) She should tear the page from the file & start documenting in the correct record
- c) She should put a straight cut over her documentation & write as wrong, sign it with her NMC code, date & time
- d) She should write as wrong documentation in a bracket & continue

**82. What are essential competencies for today's nurse manager?**

- a) strategic planning and design
- b) Self and group awareness
- c) A vision and goals
- d) Communication and teamwork

**83. A very young nurse has been promoted to nurse manager of an inpatient surgical unit. The nurse is concerned that older nurses may not respect the manager's authority because of the age difference. How can this nurse manager best exercise authority?**

- a) Maintain in an autocratic approach to influence results.
- b) Understand complex health care environments.
- c) Use critical thinking to solve problems on the unit
- d) Give assignments clearly, taking staff expertise into consideration

**84. What statement, made in the morning shift report, would help an effective manager develop trust on the nursing unit?**

- a) I know I told you that you could have the weekend off, but I really need you to work."
- b) The others work many extra shifts, why can't you?"
- c) I'm sorry, but I do not have a nurse to spare today to help on your unit. I cannot make a change now, but we should talk further about schedules and needs."
- d) I can't believe you need help with such a simple task. Didn't you learn that in school?"

**85. The nurse has just been promoted to unit manager. Which advice, offered by a senior unit manager, will help this nurse become inspirational and motivational in this new role?**

- a) "If you make a mistake with your staff, admit it, apologize, and correct the error if possible."
- b) "Don't be too soft on the staff. If they make a mistake, be certain to reprimand them immediately."
- c) "Give your best nurses extra attention and rewards for their help."
- d) "Never get into a disagreement with a staff member."

**86. The nurse executive of a health care organization wishes to prepare and develop nurse managers for several new units that the organization will open next year. What should be the primary goal for this work?**

- a) Focus on rewarding current staff for doing a good job with their assigned tasks by selecting them for promotion.
- b) Prepare these managers so that they will focus on maintaining standards of care
- c) Prepare these managers to oversee the entire health care organization
- d) Prepare these managers to interact with hospital administration.

**87. A nurse manager is planning to implement a change in the method of the documentation system for the nursing unit. Many problems have occurred as a result of the present documentation system, and the nurse manager determines that a change is required. The initial step in the process of change for the nurse manager is which of the following?**

- a) plan strategies to implement the change
- b) identify the inefficiency that needs improvement or correction
- c) identify potential solutions and strategies for the change process

**88. What are the key competencies and features for effective collaboration?**

- a) Effective communication skills, mutual respect, constructive feedback, and conflict management.
- b) High level of trust and honesty, giving and receiving feedback, and decision making.
- c) Mutual respect and open communication, critical feedback, cooperation, and willingness to share ideas and decisions.
- d) Effective communication, cooperation, and decreased competition for scarce resources.

**89. All of the staff nurses on duty noticed that a newly hired staff nurse has been selective of her tasks. All of them thought that she has a limited knowledge of the procedures. What should the manager do in this situation?**

- a) Reprimand the new staff nurse in front of everyone that what she is doing is unacceptable.
- b) Call the new nurse and talk to her privately; ask how the manager can be of help to improve her situation
- c) Ignore the incident and just continue with what she was doing.
- d) Assign someone to guide the new staff nurse until she is competent in doing her tasks.

**90. Which option best illustrates a positive outcome for managed care?**

- a) Reshaping current policy.
- b) Involvement in the political process
- c) Increase in preventative services

d) Cost-benefit analysis.

**91. Describe the primary focus of a manager in a knowledge work environment.**

- a) **Developing the most effective teams.**
- b) Taking risks
- c) Routine work.
- d) Understanding the history of the organization.

**92. What do you mean by a bad leadership?**

- a) Appreciate intuitiveness
- b) Appreciate better work
- c) **Reward poor performance**

**93. There have been several patient complaints that the staff members of the unit are disorganized and that “no one seems to know what to do or when to do it.” The staff members concur that they don’t have a real sense of direction and guidance from their leader. Which type of leadership is this unit experiencing?**

- a) Autocratic.
- b) Bureaucratic.
- c) **Laissez-faire.**
- d) Authoritarian.

**94. Ms. Castro is newly-promoted to a patient care manager position. She updates her knowledge on the theories in management and leadership in order to become effective in her new role. She learns that some managers have low concern for services and high concern for staff. Which style of management refers to this?**

- a) Organization Man
- b) Impoverished Management
- c) **Country Club Management**
- d) Team Management

**95. Ms. Jones is newly promoted to a patient care manager position. She updates her knowledge on the theories in management and leadership in order to become effective in her new role. She learns that some managers have low concern for services and high concern for staff. Which style of management refers to this?**

- a) **Country Club Management**
- b) Organization Man
- c) Impoverished Management
- d) Team Management

96. When group members are unable and unwilling to participate in making a decision, which leadership style should the nurse manager use?

- a) Participative
- b) Authorian
- c) Laissez faire
- d) Democratic

97. What is the most important issue confronting nurse managers using situational leadership?

- a) Leaders can choose one of the four leadership styles when faced with a new situation.
- b) Personality traits and leader's power base influence the leader's choice of style
- c) Value is placed on the accomplished of tasks and on interpersonal relationships between leader and group members and among group members
- d) Leadership style differs for a group whose members are at different levels of maturity

98. The nursing staff communicates that the new manager has a focus on the "bottom line," and little concern for the quality of care. What is likely true of this nurse manager?

- a) The manager is unwilling to listen to staff concerns unless they have an impact on costs.
- b) The manager understands the organization's values and how they mesh with the manger's values.
- c) The manager is communicating the importance of a caring environment.
- d) The manager is looking at the total care picture

99. An example of a positive outcome of a nurse-health team relationship would be:

- a) Receiving encouragement and support from co-workers to cope with the many stressors of the nursing role
- b) Becoming an effective change agent in the community
- c) An increased understanding of the family dynamics that affect the client
- d) An increased understanding of what the client perceives as meaningful from his or her perspective

100. What are essential competencies for today's nurse manager?

- a) vision and goals
- b) Communication and teamwork
- c) Self- and group awareness
- d) Strategic planning and design

101. The characteristic of an effective leader include:

- a) attention to detail

- b) sound problem-solving skills and strong people skills
- c) emphasis on consistent job performance
- d) all of the above

102. The following are qualities of a good leader, except:

- a) Shows empathy to members
- b) His behaviour contributes to the team
- c) Acknowledges and accepts members mistakes - without any corrections
- d) Does not accept criticisms from members

103. A nurse manger achieves a higher management position in the organisation, there is a need for what type of skills?

- a) Personal and communication skills
- b) Communication and technical skills
- c) Conceptual and interpersonal skills
- d) Visionary and interpersonal skills

104. The nurse has just been promoted to unit manager. Which advice, offered by a senior unit manager, will help this nurse become inspirational and motivational in this new role?

- a) "Don't be too soft on the staff, if they make a mistake, be certain to reprimand them immediately."
- b) "Give your best nurses extra attention and rewards for their help."
- c) "Never gets into a disagreement with a staff member."
- d) "If you make a mistake with your staff, admit it, apologize, and correct the error if possible."

105. The famous 14 Principles of Management was first defined by

- a) James Watt
- b) Adam Smith
- c) Henri Fayol
- d) Elton Mayo

106. You are a new and inexperienced staff, which of the following actions will you do during your first day on the clinical area?

- a) Acknowledge your limitations, seek supervision from your team leader
- b) volunteer to do the drug rounds
- c) help in admitting the patients
- d) answer all enquiries from the patients

107. A patient has sexual interest in you. What would you do?

- a) Just avoid it, because the problem can be the manifestation of the underlying disorder, and it will be resolved by its own as he recovers
  - b) Never attend that patient
  - c) Try to re-establish the therapeutic communication and relationship with patient and inform the manager for support
  - d) Inform police
108. One of your young patient displayed an overt sexual behaviour directly to you. How will you best respond to this?
- a) Talk to the patient about the situation, to re- establish and maintain professional boundaries and relationship
  - b) ignore the behaviour as this is part of the development process
  - c) report the patient to their relatives
  - d) inform line manager of the incident
109. A nurse from Medical-surgical unit asked to work on the orthopedic unit. The medical-surgical nurse has no orthopedic nursing experience. Which client should be assigned to the medical-surgical nurse?
- a) A client with a cast for a fractured femur & who has numbness & discoloration of the toes
  - b) A client with balanced skeletal traction & who needs assistance with morning care
  - c) A client who had an above-the-knee amputation yesterday & has a temperature of 101.4F
  - d) A client who had a total hip replacement 2 days ago & needs blood glucose monitoring
110. An RN from the women's health clinic is temporarily reassigned to a medical-surgical unit. Which of these client assignments would be most appropriate for this nurse?
- a) A newly diagnosed client with type 2 diabetes mellitus who is learning foot care
  - b) A client from a motor vehicle accident with an external fixation device on the leg
  - c) A client admitted for a barium swallow after a transient ischemic attack
  - d) A newly admitted client with a diagnosis of pancreatic cancer
111. The nurse suspects that a client is withholding health-related information out of fear of discovery and possible legal problems. The nurse formulates nursing diagnoses for the client carefully, being concerned about a diagnostic error resulting from which of the following?
- a) Incomplete data
  - b) Generalize from experience
  - c) Identifying with the client
  - d) Lack of clinical experience

**112. A nurse case manager receives a referral to provide case management services for an adolescent mother who was recently diagnosed with HIV. Which statement indicates that the patient understands her illness?**

- a) "I can never have sex again, so I guess I will always be a single parent."
- b) "I will wear gloves when I'm caring for my baby, because I could infect my baby with AIDS."
- c) "My CD4 count is 200 and my T cells are less than 14%. I need to stay at these levels by eating and sleeping well and staying healthy."
- d) "My CD4 count is 800 and my T cells are greater than 14%. I need to stay at these levels by eating and sleeping well and staying healthy."

**113. A young woman who has tested positive for HIV tells her nurse that she has had many sexual partners. She has been on an oral contraceptive & frequently had not requested that her partners use condoms. She denies IV drug use she tells her nurse that she believes that she will die soon. What would be the best response for the nurse to make.**

- a) "Where there is life there is hope"
- b) "Would you like to talk to the nurse who works with HIV- positive patient's ?"
- c) " you are a long way from dying"
- d) " not everyone who is HIV positive will develop AIDS & die"

**114. A client express concern regarding the confidentiality of her medical information. The nurse assures the client that the nurse maintains client confidentiality by:**

- a) Explaining the exact limits of confidentiality in the exchanges between the client and the nurse.
- b) Limiting discussion about clients to the group room and hallways.
- c) Summarizing the information, the client provides during assessments and documenting this summary in the chart.
- d) Sharing the information with all members of the healthcare team

**115. One busy day on your shift, a manager told you that all washes should be done by 10am. What would you do?**

- a) Follow the manager and ensure that everything is done on time.
- b) Talk to the manager and tell her that the quality of care will be compromised if washes are rushed.
- c) Ignore the manager and just continue with what you are doing.
- d) Provide a written statement of the incident.

**116. You noticed medical equipment not working while you joined a new team and the team members are not using it. Your role?**

- a) during audit raise your concern
- b) inform in written to management
- c) inform NMC

- e) take photograph

**117. When developing a program offering for patients who are newly diagnosed with diabetes, a nurse case manager demonstrates an understanding of learning styles by:**

- a) Administering a pre- and post-test assessment.
- b) Allowing patient's time to voice their opinions
- c) Providing a snack with a low glycaemic index.
- d) Utilizing a variety of educational materials.

**118. An adult has signed the consent form for a research study but has changed her mind. The nurse tells the patient that she has the right to change her mind based upon which of the following principles.**

- a) Paternalism & justice
- b) Autonomy & informed consent
- c) Beneficence & double effect
- d) Competence & right to know

**119. A famous actress has had plastic surgery. The media contacts the nurse on the unit and asks for information about the surgery. The nurse knows:**

- a) Any information released will bring publicity to the hospital
- b) Nurse are obligated to respect client's privacy and confidentiality
- c) It does not matter what is disclosed, the media will find out any way
- d) According to beneficence, the nurse has an obligation to implement actions that will benefit clients.

**120. When will you disclose the identity of a patient under your care?**

- a) You can disclose it anytime you want
- b) When a patient relative wishes to
- c) When media demands for it
- d) Justified by public interest law and order

**121. Today many individuals are seeking answers for acute and chronic health problems through non-traditional approaches to health care. What are two popular choices being selected by health consumers?**

- a) Mind awareness techniques and meditation practice
- b) Stress management and biofeedback programs
- c) Support groups and alternative medicine
- d) Telehealth and the internet

**122. Which of the following actions jeopardise the professional boundaries between patient and nurse**

- a) Focusing on social relationship outside working environment
- b) Focusing on needs of patient related to illness
- c) Focusing on withholding value opinions related to the decisions

123. **One of the main responsibilities of an employer should be:**

- a) provide a safe place for the employees 
- b) provide entertainment to employees
- c) create opportunities for growth
- d) create ways to make networks

124. **Role conflict can occur in any situation in which individuals work together. The predominant reason that role conflict will emerge in collaboration is that people have different**

- a) Levels of education and preparation
- b) Expectations about a particular role; interpersonal conflict will emerge
- c) Levels of experience and exposure of working in interdisciplinary teams
- d) Values, beliefs, and work experiences that influences their ability to collaborate.

125. **How to give respect & dignity to the client?**

- a) Compassion, support & reassurance to the client
- b) Communicate effectively with them
- c) Behaving in a professional manner
- d) Giving advice on health care issues

126. **A patient with antisocial personality disorder enters the private meeting room of a nursing unit as a nurse is meeting with a different patient. Which of the following statements by the nurse is BEST?**

- a) Please leave and I will speak with you when I am done."
- b) I need you to leave us alone."
- c) You may sit with us as long as you are quiet."
- d) I'm sorry, but HIPPA says that you can't be here. Do you mind leaving?"

127. **A client on your medical surgical unit has a cousin who is physician & wants to see the chart. Which of the following is the best response for the nurse to take**

- a) Ask the client to sign an authorization & have someone review the chart with cousin
- b) Hand the cousin the client chart to review
- c) Call the attending physician & have the doctor speak with the cousin
- d) Tell the cousin that the request cannot be granted

128. As an RN in charge you are worried about a nurse's act of being very active on social media site, that it affect the professionalism. Which one of these is the worst advice you can give her?
- a) Do not reveal your profession of being a Nurse on social site
  - b) Do not post any pictures of client's even if they have given you permission
  - c) Do not involve in any conversations with client's or their relatives through a social site
  - d) Keep your profile private
129. Compassion in Practice – the culture of compassionate care encompasses:
- a) Care, Compassion, Competence, Communication, Courage, Commitment - DoH–“Compassion in Practice”
  - b) Care, Compassion, Competence
  - c) Competence, Communication, Courage
  - d) Care, Courage, Commitment
130. You walk onto one of the bay on your ward and noticed a colleague wrongly using a hoist in transferring their patient. As a nurse you will:
- a) let them continue with their work as you are not in charge of that bay
  - b) report the event to the unit manager
  - c) call the manual handling specialist nurse for training
  - d) inform the relatives of the mistake
131. You are to take charge of the next shift of nurses. Few minutes before your shift, the in charge of the current shift informed you that two of your nurses will be absent. Since there is a shortage of staff in your shift, what will you do?
- a) encourage all the staff who are present to do their best to attend to the needs of the patients
  - b) ask from your manager if there are qualified staff from the previous shift that can cover the lacking number for your shift while you try to replace new nurses to cover
  - c) refuse to take charge of the next shift
132. Who will you inform first if there is a shortage in supplies in your shift?
- a) Nursing assistant
  - b) Purchasing personnel
  - c) Immediate nurse manager
  - d) Supplier
133. The supervisor reprimands the charge nurse because the nurse has not adhered to the budget. Later the charge nurse accuses the nursing staff of wasting supplies. This is an example of

- a) Denial
- b) Repression
- c) Suppression
- d) Displacement



134. A nurse is having trouble with doing care plans. Her team members are already noticing this problem and are worried of the consequences this may bring to the quality of nursing care delivered. The problem is already brought to the attention of the nurse. The nurse should:
- a) Accept her weakness and take this challenge as an opportunity to improve her skills by requesting lectures from her manager
  - b) Ignore the criticism as this is a case of a team issue
  - c) Continue delivering care as this will not affect the quality of care you are rendering your patient
135. Clinical audit is best described as:
- a) a tool to evaluate the effectiveness of interventions, and to know what needs to be improved
  - b) a tool used to identify the weakest link within the system
  - c) a standard of which performance is based upon
  - d) a tool to set a guidelines or protocol in clinical practice
136. You are the nurse on Ward C with 14 patients. Your fellow incoming nurses called in sick and cannot come to work on your shift. What will be your best action on this situation?
- a) Review patient intervention, set priorities, ask the supervisor to hand over extra staff
  - b) continue with your shift and delegate some responsibilities to the nursing assistant
  - c) fill out an incident form about the staffing condition
  - d) ask the colleague to look for someone to cover
137. A client requests you that he wants to go home against medical advice, what should you do?
- a) Inform the management
  - b) Inform the local police
  - c) Call the security guard
  - d) Allow the client to go home as he won't pose any threat to self or others
138. The nurse is leading an in service about management issues. The nurse would intervene if another nurse made which of the following statements?

- a) "It is my responsibility to ensure that the consent form has been signed and attached to the patient's chart prior to surgery."
  - b) "It is my responsibility to witness the signature of the client before surgery is performed."
  - c) "It is my responsibility to answer questions that the patient may have prior to surgery."
  - d) "It is my responsibility to provide a detailed description of the surgery and ask the patient to sign the consent form."
139. After finding the patient, which statement would be most appropriate for the nurse to document on a datix/incident form?
- a) "The patient climbed over the side rails and fell out of bed."
  - b) "The use of restraints would have prevented the fall."
  - c) "Upon entering the room, the patient was found lying on the floor."
  - d) "The use of a sedative would have helped keep the patient in bed."
140. A nurse documents vital signs without actually performing the task. Which action should the charge nurse take after discussing the situation with the nurse?
- a) Charge the nurse with malpractice
  - b) Document the incident
  - c) Notify the board of nursing
  - d) Terminate employment
141. A patient in your care knocks their head on the bedside locker when reaching down to pick up something they have dropped. What do you do?
- a) Let the patient's relatives know so that they don't make a complaint & write an incident report for yourself so you remember the details in case there are problems in the future
  - b) Help the patient to a safe comfortable position, commence neurological observations & ask the patient's doctor to come & review them, checking the injury isn't serious. when this has taken place , write up what happened & any future care in the nursing notes
  - c) Discuss the incident with the nurse in charge , & contact your union representative in case you get into trouble
  - d) Help the patient to a safe comfortable position, take a set of observations & report the incident to the nurse in charge who may call a doctor. Complete an incident form. At an appropriate time, discuss the incident with the patient & if they wish, their relatives
142. The rehabilitation nurse wishes to make the following entry into a client's plan of care: "Client will re-establish a pattern of daily bowel movements without straining within two months." The nurse would write this statement under which section of the plan of care?

- a) Nursing diagnosis/problem list
  - b) Nursing order
  - c) Short-term goals
  - d) Long term goals
143. A registered nurse identifies a care assistant not washing hands hand before caring an immunocompromised client. Your response?
- a) Let her do the procedure. Correct her later
  - b) Inform to ward in charge
  - c) Interrupt the procedure, correct her politely, teach her 6 steps of handwashing and make sure she became competent
144. The bystander of a muslim lady wishes that a lady doctor only should check the patient. Best response
- a) Just neglect the request
  - b) Tell her that, only male doctor is available and he is takin care of many female staffs daily
  - c) Respect the request, if possible arrange the consultation with a female doc
  - d) Inform police
145. Bystander informs you that the patient is in severe pain. Ur response
- a) Tell him that he would come as soon as possible
  - b) Record in the chart and inform doc and in charge
  - c) Tell that she would give the next dose of analgesic when it's time
  - d) Go instantly to the patient and assess the condition
146. The nurse restrains a client in a locked room for 3 hours until the client acknowledges who started a fight in the group room last evening. The nurse's behaviour constitutes:
- a) False imprisonment
  - b) Duty of care
  - c) Standard of care practice
  - d) Contract of care
147. Role conflict can occur in any situation in which individuals work together. The predominant reasons that role conflict will emerge in collaboration is that people have different:
- a) Levels of education and preparation
  - b) Expectations about a particular role; interpersonal conflict will emerge
  - c) Levels of experience and exposure of working in interdisciplinary teams
  - d) Values, beliefs, and work experiences that influence their ability to collaborate.

148. **What are the characteristics of effective collaboration?**
- a) Common purpose and goals
  - b) Clinical competence of each provider
  - c) Humor, trust, and valuing diverse, complementary knowledge
  - d) **All of the above**
149. **A client has been voluntarily admitted to the hospital. The nurse knows that which of the following statements is inconsistent with this type of hospitalization?**
- a) The client retains all of his or her rights
  - b) the client has a right to leave if not a danger to self or others
  - c) the client can sign a written request for discharge
  - d) **The client cannot be released without medical advice**
150. **If you were explaining anxiety to a patient, what would be the main points to include?**
- a) Signs of anxiety include behaviours such as muscle tension, palpitations, a dry mouth, fast shallow breathing, dizziness & an increased need to urinate or defaecate
  - b) **Anxiety has three aspects: physical – bodily sensations related to flight & fight response, behavioural – such as avoiding the situation, & cognitive (thinking) – such as imagining the worst**
  - c) Anxiety is all in the mind, if they learn to think differently, it will go away
  - d) Anxiety has three aspects: physical – such as running away, behavioural – such as imagining the worse (catastrophizing) , & cognitive ( thinking) – such as needing to urinate.
151. **A 23-year-old-woman comes to the emergency room stating that she had been raped. Which of the following statements BEST describes the nurse's responsibility concerning written consent?**
- a) **The nurse should explain the procedure to the patient and ask her to sign the consent form.**
  - b) **The nurse should verify that the consent form has been signed by the patient and that it is attached to her chart.**
  - c) The nurse should tell the physician that the patient agrees to have the examination.
  - d) The nurse should verify that the patient or a family member has signed the consent form.
152. **A 52-year-old man is admitted to a hospital after sustaining a severe head injury in an automobile accident. When the patient dies, the nurse observes the patient's wife comforting other family members. Which of the following interpretations of this behaviour is MOST justifiable?**

- a) She has already moved through the stages of the grieving process.
  - b) She is repressing anger related to her husband's death.
  - c) **She is experiencing shock and disbelief related to her husband's death.**
  - d) She is demonstrating resolution of her husband's death.
153. The nurse works on a medical/surgical unit that has a shift with an unusually high number of admissions, discharges, and call bells ringing. A nurse's aide, who looks increasingly flustered and overwhelmed with the workload, finally announces "This is impossible! I quit!" and stomps toward the break room. Which of the following statements, if made by the nurse to the nurse's aide, is BEST?
- a) fine, we're better off without you anyway"
  - b) **It seems to me that you feel frustrated. What can I help you with to care for our patients?"**
  - c) I can understand why you're upset, but I'm tired too and I'm not quitting."
  - d) Why don't you take a dinner break and come back? It will seem more manageable with a normal blood sugar.
154. The nurse cares for a client diagnosed with conversion reaction. The nurse identifies the client is utilizing which of the following defence mechanisms?
- a) Introjection
  - b) Displacement
  - c) Identification
  - d) **Repression**
155. A young woman has suffered fractured pelvis in an accident , she has been hospitalized for 3 days , when she tells her primary nurse that she has something to tell her but she does not want the nurse to tell anyone. she says that she had tried to donate blood & tested positive for HIV. what is best action of the nurse to take?
- a) Document this information on the patient's chart
  - b) Tell the patient's physician
  - c) Inform the healthcare team who will come in contact with the patient
  - d) **Encourage the patient to disclose this information to her physician**
156. The nurse is in the hospitals public cafeteria & hears two nursing assistants talking about the patient in 406. they are using her name & discussing intimate details about her illness which of the following actions are best for the nurse to take?
- a) **Go over & tell the nursing assistants that their actions are inappropriate especially in a public place**
  - b) Wait & tell the assistants later that they were overheard discussing the patient otherwise they might be embarrassed

- c) Tell the nursing assistant's supervisor about the incident. It is the supervisor's responsibility to address the issue
  - d) Say nothing. it is not the nurses job, he or she is not responsible for the assistant's action
157. **A young woman who has tested positive for HIV tells her nurse that she has had many sexual partners. She has been on an oral contraceptive & frequently had not requested that her partners use condoms. She denies IV drug use she tells her nurse that she believes that she will die soon. What would be the best response for the nurse to make.**
- a) "Where there is life there is hope"
  - b) " **Would you like to talk to the nurse who works with HIV- positive patient's ?**"
  - c) " you are a long way from dying"
  - d) " not everyone who is HIV positive will develop AIDS & die"
158. **One of your patient was pleased with the standard of care you have provided him. As a gesture, he is giving you a £50 voucher to spend. What is your most appropriate action on this situation?**
- a) Accept the voucher and thank him for this gesture
  - Refuse the voucher and thank him for this gesture**
  - C. Accept the voucher and give it to ward manager
  - D. Refuse the voucher and inform the ward manager for his gesture
159. **The nurse is functioning as a patient advocate. Which of the following would be the first step the nurse should take when functioning in this role?**
- a) Ensure that the nursing process is complete and includes active participation by the patient and family**
  - b) Become creative in meeting patient's needs.
  - c) Empower the patient by providing needed information and support.
  - d) Help the patient understand the need for preventive health care.
160. **The nurse manager of 20 bed coronary care is not on duty when a staff nurse makes serious medication error. The client who received an over dose of the medication nearly dies. Which statement of the nurse manager reflects accountability?**
- a) **The nurse supervisor on duty will call the nurse manager at home and apprise about the problem**
  - b) Because the nurse manager is not on duty therefore she is not accountable to anything which happens on her absence**
  - c) The nurse manager will be informed of the incident when returning to the work on Monday because the nurse manager was officially off duty when the incident took place.
  - d) Although the nurse manager was on off duty but the nurse supervisor decides to call nurse manager if the time permits the nurse supervisor thinks that the

nurse manager has no responsibility of what has happened in manager's absence

161. **All individuals providing nursing care must be competent at which of the following procedures?**

- a) Hand hygiene and aseptic technique
- b) Aseptic technique only
- c) **Hand hygiene, use of protective equipment, and disposal of waste**
- d) Disposal of waste and use of protective equipment
- e) All of the above

162. **Clinical bench-marking is:**

- a) **to improve standards in health care**
- b) a new initiate in health care system
- c) A new set of rule for health care professionals
- d) To provide a holistic approach to the patient

163. **What do you mean by benchmarking tool ?**

- a) **an overall patient-focused outcome that expresses what patients and or carers want from care in a particular area of practice**
- b) it is the way of expressing the need of the patient
- c) a continuum between poor and best practice.
- d) information on how to use the benchmarks

164. **Essence of Care benchmarking is a process of -----?**

- a) **Comparing, sharing and developing practice in order to achieve and sustain best practice.**
- b) Assess clinical area against best practice
- c) Review achievement towards best practice
- d) Consultation and patient involvement

165. **Wendy, 18 years old, was admitted on Medical Ward because of recurrent urinary tract infection (UTI). She disclosed to you that she had unprotected sex with her boyfriend on some occasions. You are worried this may be a possible cause of the infection. How will best handle the situation?**

- a) tell her that any information related to her wellbeing will need to be share to the health care team
- b) inform her parents about this so she can be advised appropriately
- c) **keep the information a secret in view of confidentiality**
- d) report her boyfriend to social services

166. **When trying to make a responsible ethical decision, what should the nurse understand as the basis for ethical reasoning?**
- a) **Ethical principles & code**
  - b) The nurse's experience
  - c) The nurse's emotional feelings
  - d) The policies & practices of the institution
167. **A mentally competent client with end stage liver disease continues to consume alcohol after being informed of the consequences of this action. What action best illustrates the nurse's role as a client advocate?**
- a) Asking the spouse to take all the alcohol out of the house
  - b) **Accepting the patient's choice & not intervening**
  - c) Reminding the client that the action may be an end-of life decision
  - d) Refusing to care for the client because of the client's noncompliance
168. **While at outside setup what care will you give as a Nurse if you are exposed to a situation?**
- a) Provide care which is at expected level
  - b) **keeping up to professional standards**
  - c) above what is expected
  - d) Ignoring the situation
169. **when breaking bad news over phone which of the following statement is appropriate**
- a) **I am sorry to tell you that your mother died**
  - b) I am sorry to tell you that your mother has gone to heaven
  - c) I am sorry to tell you that your mother is no more
  - d) I am sorry to tell you that your mother passed away
170. **A patient with complex, multiple diseases is discharged to a tertiary level care unit what to do?**
- a) **Inform the tertiary unit about patient arrival**
  - b) **Call for a multidisciplinary meeting with professional who took care of patient to discuss the patient care modalities that everyone accepts.**
  - c) Inform to patient relatives about the situation
171. **clinical practice is based on evidence based practice. Which of the following statements is true about this**
- a) **Clinical practice based on clinical expertise and reasoning with the best knowledge available**
  - b) Provision of computers at every nursing station to search for best evidence while providing care
  - c) Practice based on ritualistic way

- d) Practice based on what nurse thinks is the best for patient  
n adult has just returned to the unit from surgery. The nurse transferred him to his bed but did not put up the side rails.
172. **The client fell and was injured. What kind of liability does the nurse have?**
- a) None
  - b) Negligence
  - c) Intentional tort
  - d) Assault & battery
173. **A new RN have problems with making assumptions. Which part of the code she should focus to deliver fundamentals of care effectively**
- a) Prioritise people
  - b) Practice effective
  - c) Preserve safety
  - d) Promote professionalism and trust
174. **A patient with learning disability is accompanied by a voluntary independent mental capacity advocate. What is his role?**
- a) Express patients' needs and wishes. Acts as a patient's representative in expressing their concerns as if they were his own
  - b) Just to accompany the patient
  - c) To take decisions on patients behalf and provide their own judgements as this benefit the client
  - d) Is an expert and repenetrates clients concerns, wishes and views as they cannot express by themselves
175. **When you find out that 2 staffs are on leave for next duty shift and its of staff shortage what to do with the situation?**
- a) Inform the superiors and call for a meeting to solve the issue
  - b) Contact a private agency to provide staff
  - c) Close the admission until adequate staffs are on duty.
176. **A young woman has suffered fractured pelvis in an accident, she has been hospitalized for 3 days , when she tells her primary nurse that she has something to tell her but she does not want the nurse to tell anyone. she says that she had tried to donate blood & tested positive for HIV. what is best action of the nurse to take?**
- a) Document this information on the patient's chart

- b) Tell the patient's physician
- c) Inform the healthcare team who will come in contact with the patient
- d) **Encourage the patient to disclose this information to her physician**

177. **What is Disclosure according to NHS?**

- a) It is asking action to help people say what they want, secure their rights, represent their interests and obtain the services they need
- b) **This is the divulging or provision of access to data.**
- c) It is the response to the suffering of others that motivates a desire to help.
- d) It is a set of rules or a promise that limits access or places restrictions on certain types of information.

178. **Wound care management plan should be done with what type of wound?**

- a) Complex wound
- b) Infected wound
- c) **Any type of wound**

179. **Wound proliferation starts after?**

- a) 1-5 days
- b) **3-24 days**
- c) 24 days

180. **How long does proliferative phase of wound healing occur?**

- a) **3-24 days**
- b) 24-26 days
- c) 1-7 days
- d) 24 hours

181. **How long does the 'inflammatory phase' of wound healing typically last?**

- a) 24 hours
- b) Just minutes
- c) **1-5 days**
- d) 3-24 days

182. **A new, postsurgical wound is assessed by the nurse and is found to be hot, tender and swollen. How could this wound be best described?**

- a) **In the inflammation phase of healing.**
- b) In the haemostasis phase of healing.
- c) In the reconstructive phase of wound healing.
- d) As an infected wound

**183. What are the four stages of wound healing in the order they take place?**

- a) Proliferative phase, inflammation phase, remodelling phase, maturation phase.
- b) **Haemostasis, inflammation phase, proliferation phase, maturation phase**
- c) Inflammatory phase, dynamic stage, neutrophil phase, maturation phase.
- d) Haemostasis, proliferation phase, inflammation phase, remodelling phasesupport

**184. Breid, 76 years old, developed a pressure ulcer whilst under your care. On assessment, you saw some loss of dermis, with visible redness, but not sloughing off. Her pressure ulcer can be categorised as:**

- a) moisture lesion
- b) **2nd stage partial skin thickness**
- c) 3rd stage
- d) 4th stage

**185. What stage of pressure ulcer includes tissue involvement and crater formation? (CHOOSE 2 ANSWERS)**

- a) stage 1
- b) **stage 2**
- c) **stage 3**
- d) stage 4



**186. What stage of pressure ulcer includes tissue involvement and crater formation?**

- a) stage 1
- b) **stage 2**
- c) stage 3
- d) stage 4

**187. A clients wound is draining thick yellow material. The nurse correctly describes the drainage as:**

- a) Sanguineous
- b) Serous sanguineous
- c) Serous
- d) **Purulent**

**188. What do you expect to assess in a grade 3 pressure ulcer?**

- a) blistered wound on the skin
- b) **open wound showing tissue**
- c) open wound exposing muscles
- d) open wound exposing bones

189. A nurse notices a bedsore. It's a shallow wound, red coloured with no pus. Dermis is lost. At what stage this bedsore is?
- a) Stage1- non blanchable erythema
  - b) Stage2- Partial thickness skin loss
  - c) Stage3- full thickness skin loss
  - d) Stage4- full thickness tissue loss
190. Breid, 76 years old, developed a pressure ulcer whilst under your care. On assessment, you saw some loss of dermis, with visible redness, but not sloughing off. Her pressure ulcer can be categorised as:
- a) moisture lesion
  - b) 2nd stage partial skin thickness
  - c) 3rd stage
  - d) 4th stage
191. A patient developed pressure ulcer. The wound is round, extends to the dermis, is shallow, there is visible reddish to pinkish tissue. What stage is the pressure ulcer?
- a) Stage 1
  - b) Stage 2
  - c) Stage 3
  - d) Stage 4
192. a client is admitted to the Emergency Department after a motorcycle accident that resulted in the client's skidding across a cement parking lot. Since the client was wearing shorts, there are large areas on the legs where the skin is ripped off. The wound is best described as:
- a) Abrasion
  - b) Unapproximated
  - c) Laceration
  - d) Eschar
193. Joshua, son of Breid went to the station to see the nurse as she was complaining of severe pain on her pressure ulcer. What will be your initial action?
- a) Check analgesia on the chart
  - b) Tell you will come as soon as you can
  - c) Find the nurse in charge
  - d) Go immediately to see the patient
194. When would it be beneficial to use a wound care plan?
- a) On all chronic wounds
  - b) On all infected wounds.
  - c) On all complex wounds.

d) On every wound

195. When would it be beneficial to use a wound care plan?

- a) on initial assessment of wound
- b) during pre-assessment admission
- c) after surgery
- d) during wound infection, dehiscence or evisceration
- e) When would it be beneficial to use a wound care plan? (CHOOSE 3 ANSWERS)

196. Which of the following methods of wound closure is most suitable for a good cosmetic result following surgery?

- a) Skin clips
- b) Tissue adhesive 
- c) Adhesive skin closure strips
- d) Interrupted suture

197. What functions should a dressing fulfil for effective wound healing?

- a) High humidity, insulation, gaseous exchange, absorbent. 
- b) Anaerobic, impermeable, conformable, low humidity.
- c) Insulation, low humidity, sterile, high adherence.
- d) Absorbent, low adherence, anaerobic, high humidity.

198. Appropriate wound dressing criteria includes all but one:

- a) Allows gaseous exchange.
- b) Maintains optimum temperature and pH in the wound.
- c) Forms an effective barrier to
- d) Allows removal of the dressing without pain or skin stripping.
- e) Is non-absorbent

199. Proper Dressing for wound care should be? (Select x 3 correct answers)

- a) High humidity
- b) Low humidity
- c) Non Permeable/ Conformable
- d) Absorbent / Provide thermal insulation

200. Which of the following conditions can be observed in a proper wound dressing:

- a) absorbent, humid, aerated 
- b) non absorbent, humid, aerated
- c) non humid, absorbent, aerated

- d) non humid, non absorbent, aerated

201. **Proper Dressing for wound care should be?**

- a) High humidity
- b) Low humidity
- c) Non Permeable
- d) Conformable
- e) Adherent
- f) Absorbent
- g) Provide thermal insulation

202. **You notice an area of redness on the buttock of an elderly patient and suspect they may be at risk of developing a pressure ulcer. Which of the following would be the most appropriate to apply?**

- a) Negative pressure dressing
- b) Rapid capillary dressing
- c) Alginate dressing
- d) Skin barrier product

203. **Which solution use minimum tissue damage while providing wound care?**

- a) Hydrogen peroxide
- b) Povidine iodine
- c) Saline
- d) Gention violet

204. **Which are not the benefits of using negative pressure wound therapy?**

- a) Can reduce wound odour
- b) Increases local blood flow in peri-wound area
- c) Can be used on untreated osteomyelitis
- d) Can reduce use of dressings

205. **Which one of the following types of wound is NOT suitable for negative pressure wound therapy?**

- a) Partial thickness burns
- b) Contaminated wounds
- c) Diabetic and neuropathic ulcers
- d) Traumatic wounds

206. **How do you remove a negative pressure dressing?**

- a) Remove pressure then detach dressing gently

- b) Get TVN nurse to remove dressing
- c) remove in a quick fashion

**207. How would you care for a patient with a necrotic wound?**

- a) Systemic antibiotic therapy and apply a dry dressing
- b) Debride and apply a hydrogel dressing.
- c) Debride and apply an antimicrobial dressing.
- d) Apply a negative pressure dressing.

**208. The nurse cares for a patient with a wound in the late regeneration phase of tissue repair. The wound may be protected by applying a:**

- a) Transparent film
- b) Hydrogel dressing
- c) Collagenases dressing
- d) Wet dry dressing

**209. Black wounds are treated with debridement. Which type of debridement is most selective and least damaging?**

- a) Debridement with scissors
- b) Debridement with wet to dry dressings
- c) Mechanical debridement
- d) Chemical debridement

**210. If an elderly immobile patient had a "grade 3 pressure sore", what would be your management?**

- a) Film dressing, mobilization, positioning, nutritional support
- b) Foam dressing, pressure relieving mattress, nutritional support
- c) Dry dressing, pressure relieving mattress, mobilization
- d) Hydrocolloid dressing, pressure relieving mattress, nutritional support

**211. A client has a diabetic stasis ulcer on the lower leg. The nurse uses a hydrocolloid dressing to cover it. The procedure for application includes:**

- a) Cleaning the skin and wound with betadine
- b) Removing all traces of residues for the old dressing
- c) Choosing a dressing no more than quarter-inch larger than the wound size
- d) Holding it in place for a minute to allow it to adhere

**212. The client at greatest risk for postoperative wound infection is:**

- a) A 3 month old infant postoperative from pyloric stenosis repair
- b) A 78 year old postoperative from inguinal hernia repair

- c) A 18 year old drug user postoperative from removal of a bullet in the leg
  - d) A 32 year old diabetic postoperative from an appendectomy
213. Mr Connor's neck wound needed some cleaning to prevent complications. Which of the following concept will you apply when doing a surgical wound cleaning?
- a) surgical asepsis
  - b) aseptic non-touch technique
  - c) medical asepsis
  - d) dip-tip technique
214. When doing your shift assessment, one of your patient has a waterflow score of 20. Which of the following mattress is appropriate for this score?
- a) water bed
  - b) fluidized airbed
  - c) low air loss
  - d) alternating pressure
215. Waterlow score of 20 indicates what type of mattress to use? Select x 2
- a) Standard-specification foam mattresses
  - b) High-specification foam mattresses
  - c) Dynamic support surface
216. For a client with Water Score >20 which mattress is the most suitable
- a) Water Mattress
  - b) Air Mattress
  - c) Dynamic Mattress
  - d) Foam Mattress
217. A patient has been confined in bed for months now and has developed pressure ulcers in the buttocks area. When you checked the waterlow it is at level 20. Which type of bed is best suited for this patient?
- a) water mattress
  - b) Egg crater mattress
  - c) air mattresses
  - d) Dynamic mattress
218. A patient has been confined in bed for months now and has developed pressure ulcers in the buttocks area. When you checked the waterlow it is at level 20. Which type of bed is best suited for this patient?
- a) water mattress
  - b) Egg crater mattress
  - c) air mattresses

d) **Dynamic mattress**

219. **You have just finished dressing a leg ulcer. You observe patient is depressed and withdrawn. You ask the patient whether everything is okay. She says yes. What is your next action?**

- a) **Say " I observe you don't seem as usual. Are you sure you are okay?"**
- b) Say "Cheer up , Shall I make a cup of tea for you?"
- c) Accept her answer & leave. attend to other patients
- d) Inform the doctor about the change of the behaviour.

220. **Mrs Smith developed an MRSA bacteremia from her abdominal wound and her son is blaming the staff. It has been highlighted during your ward clinical governance meeting because it has been reported as a serious incident (SI). SI is best described as:**

- a) any incident or occurrence that has the potential to cause harm and/or has caused harm to a person or persons
- b) a consequence of an intervention, relating to a piece of equipment and/or as a consequence of the working environment
- c) Incident requiring investigation that occurred in relation to NHS funded services and care resulting in; unexpected or avoidable death, permanent harm
- d) **All**

221. **How much urine should someone void an hour?**

- a) **0.5 – 1ml/Kg/hr of the patient's body weight**
- b) 2mls/KG/hr of the patient's body weight
- c) 30mls
- d) 50mls

222. **Patient usually urinates at night Nurse identifies this as:**

- A) Polyuria
- B) Oliguria
- C) Nocturia**

223. **Wendy, 18 years old, was admitted on Medical Ward because of recurrent urinary tract infection (UTI). She disclosed to you that she had unprotected sex with her boyfriend on some occasions. You are worried this may be a possible cause of the infection. How will best handle the situation?**

- A) tell her that any information related to her well being will need to be share to the health care team**
- B) inform her parents about this so she can be advised appropriately

- C) keep the information a secret in view of confidentiality
- D) report her boyfriend to social services

224. **What are the steps for the proper urine collection?**

- a) Clean meatus with soap and water
  - b) Catch midstream
  - c) Dispatch sample to laboratory immediately (within 6 hours)
  - d) Ask the patient to void her remaining urine into the toilet or bedpan.
- 
- a) A, B, & C
  - b) B, C, & D
  - c) **A, B, & D**
  - d) A, C, & D

225. **On removing your patient's catheter, what should you encourage your patient to do ?**

- a) Rest & drink 2-3 litres of fluid per day
- b) Rest & drink in excess of 5 litres of fluid per day
- c) **Exercise & drink 2-3 litres of fluid per day**
- d) Exercise & drink their normal amount of fluid intake

226. **When should a penile sheath be considered as a means of managing incontinence?**

- a) **When other methods of continence management have failed**
- b) Following the removal of a catheter
- c) When the patient has a small or retracted penis
- d) When a patient requests it

227. **What is the most important guiding principle when choosing the correct size of catheter?**

- a) The biggest size tolerable
- b) **The smallest size necessary**
- c) The potential length of use of the catheter
- d) The build of the patient

228. **When carrying out a catheterization, on which patients would you use anaesthetic lubricating gel prior to catheter insertion?**

- a) Male patients to aid passage, as the catheter is longer
- b) Female patients as there is an absence of lubricating glands in the female urethra , unlike the male urethra
- c) **Male & female patients require anaesthetic lubricating gel**
- d) The use of anaesthetic lubricating gel is not advised due to potential adverse reactions

229. **What are the principles of positioning a urine drainage bag?**
- a) Above the level of the bladder to improve visibility & access for the health professional
  - b) Above the level of the bladder to avoid contact with the floor
  - c) **Below the level of the patient's bladder to reduce backflow of urine**
  - d) Where the patient finds it most comfortable
230. **What would make you suspect that a patient in your care had a urinary tract infection?**
- a) **The patient has spiked a temperature, has a raised white cell count (WCC), has new-onset confusion & the urine in the catheter bag is cloudy**
  - b) The doctor has requested a midstream urine specimen
  - c) The patient has a urinary catheter in situ & the patient's wife states that he seems more forgetful than usual
  - d) The patient has complained of frequency of faecal elimination & hasn't been drinking enough
231. **Which of the following population group is at risk of developing cardiovascular disease?**
- a) **Obese, male, diabetic, hypertensive, sedentary lifestyle** 
  - b) female, forty, fertile
  - c) **smoker, diabetic and alcoholic**
  - d) **drug user, male, hypertensive**
232. **All are risk factors of Coronary Artery Disease except:**
- A. Obesity
  - B. Smoking
  - C. High Blood Pressure
  - D. **Female**
233. **Which of the following is at a greater risk for developing coronary artery disease?**
- a) **Male, obese, sedentary lifestyle**
  - b) **Female, obese, non sedentary lifestyle**
234. **When should adult patients in acute hospital settings have observations taken?**
- a) **When they are admitted or initially assessed. A plan should be clearly documented which identifies which observations should be taken & how frequently subsequent observations should be done**
  - b) When they are admitted & then once daily unless they deteriorate
  - c) As indicated by the doctor

- d) Temperature should be taken daily, respirations at night , pulse & blood pressure 4 hourly
235. **When is the time to take the vital signs of the patients? Select which does not apply:**
- a) At least once every 12 hours, unless specified otherwise by senior staff.
  - b) When they are admitted or initially assessed.
  - c) On transfer to a ward setting from critical care or transfer from one ward to another.
  - d) Every four hours
236. **Which sign or symptom is a key indication of progressive arterial insufficiency?**
- a) Oedema
  - b) Hyperpigmentation of the skin
  - c) Pain
  - d) Cyanosis
237. **If Tony's heart rate slows down, this is referred to as:**
- A) hypertension
  - B) hypotension
  - C) bradycardia
  - D) tachycardia
238. **Why is it important to manually assess pulse rate?**
- a) Amplitude, volume and irregularities cannot be detected using automated electronic methods
  - b) Tachycardia cannot be detected using automated electronic methods
  - c) Bradycardia cannot be detected using automated electronic method
  - d) It is more reassuring to the patient
239. **A patient on your ward complains that her heart is 'racing' and you find that the pulse is too fast to manually palpate. What would your actions be?**
- a) Shout for help and run to collect the crash trolley.
  - b) Ask the patient to calm down and check her most recent set of bloods and fluid balance.
  - c) A full set of observations: blood pressure, respiratory rate, oxygen saturation and temperature. It is essential to perform a 12 lead ECG. The patient should then be reviewed by the doctor.
  - d) Check baseline observations and refer to the cardiology team.
240. **Orthostatic hypotension is diagnosed if the systolic blood pressure drops by how many mmHg?**



- A) 20
- B) 25
- C) 30
- D) 35

241. When would an orthostatic blood pressure measurement be indicated?

- A) If the patient has a recent history of falls.
- B) If the patient has a history of dizziness or syncope on changing position.
- C) If the patient has a history of hypertension.
- D) If the patient has a history of hypotension

242. Which is not a cause of postural hypotension?

- a) the time of day
- b) lack of exercise
- c) temperature
- d) recent food intake

243. What do the adverse effects of hypotension include?

- A) Decreased conscious level, reduced blood flow to vital organs and renal failure.
- B) The patient could become confused and not know who they are.
- C) Decreased conscious level, oliguria and reduced coronary blood flow.
- D) The patient feeling very cold



244. Mrs Red is complaining of shortness of breath. On assessment, her legs are swollen indicative of tissue oedema. What do you think is the possible cause of this?

- a) left side heart failure
- b) right side heart failure
- c) renal failure
- d) liver failure

245. In interpreting ECG results if there is clear evidence of atrial disruption this is interpreted as?

- a) Cardiac Arrest
- b) Ventricular tach
- c) Atrial Fibrillation
- d) Complete blockage of the heart

246. A client is having diagnosed atrial activity. identify the ECG

- a) Atrial fibrillation
- b) cardiac arrest

- c) ventricular tachycardia
- d) asystole

**247. What is atrial fibrillation?**

- a) heart condition that causes,
- b) An irregular and often abnormally slow heart rate
- c) **An irregular and often abnormally fast heart rate**
- d) A regular heart rhythm with an abnormally slow heart rate
- e) A regular heart rhythm with an abnormally fast heart rate

**248. The correct management of an adult patient in ventricular fibrillation (VF) cardiac arrest includes:**

- A) **an initial shock with a manual defibrillator or when prompted by an automated external defibrillator (AED)**
- B) **atropine 3 mg IV**
- C) adenosine 500 mcg IV
- D) adrenaline 1 mg IV before first shock

**249. How to act in an emergency in a health care set up?**

- A) according to the patient's condition
- B) according to instruction
- C) according to situation
- D) **according to our competence**

**250. While having lunch at the cafeteria, your co-worker suddenly collapsed. As a nurse, what would you do?**

- A) You are on lunch, no actions should be taken
- B) **Assess for any danger**
- C) Tap the patient to check for consciousness
- D) Call for help

**251. Which is the first drug to be used in cardiac arrest of any aetiology?**

- a) **Adrenaline**
- b) Amiodarone
- c) Atropine
- d) Calcium chloride

**252. During cardiopulmonary resuscitation:**

- A) **chest compression should be 5-6 cm deep at a rate of 100-120 compression per minute**
- B) **a ratio of 2 ventilation to 15 cardiac compression is required**

- C) the hands should be placed over the lower third of the sternum to do chest compression
- D) check for normal breathing for 1 full minute to diagnose cardiac arrest

253. You are currently on placement in the emergency department (ED). A 55-year-old city worker is blue lighted into the ED having had a cardiorespiratory arrest at work. The paramedics have been resuscitating him for 3 minutes. On arrival, he is in ventricular fibrillation. Your mentor asks you the following question prior to your shift starting: What will be the most important part of the patient's immediate advanced life support?

- a) Early defibrillation to restart the heart.
- b) Early cardiopulmonary resuscitation.
- c) Administration of adrenaline every 3 minutes.
- d) Correction of reversible causes of hypoxia.

254. In Spinal cord injury patients, what is the most common cause of autonomic dysreflexia ( a sudden rise in blood pressure)?

- a) Bowel obstruction
- b) Fracture below the level of the spinal lesion
- c) Pressure sore
- d) Urinary obstruction

255. Most commonly aneurysms can develop on? Select x 2 answers

- a) Abdominal aorta
- b) Circle of Willis
- c) Intraparenchymal aneurysms
- d) Capillary aneurysms

256. Which of the following can a patient not have if they have a pacemaker in situ?

- A) MRI
- B) X ray
- C) Barium swallow
- D) CT

257. You are looking after a postoperative patient and when carrying out their observations, you discover that they are tachycardic and anxious, with an increased respiratory rate. What could be happening? What would you do?

- A. The patient is showing symptoms of hypovolaemic shock. Investigate source of fluid loss, administer fluid replacement and get medical support.
- B. The patient is demonstrating symptoms of atelectasis. Administer a nebulizer, refer to physiotherapist for assessment.
- C. The patient is demonstrating symptoms of uncontrolled pain. Administer prescribed analgesia, seek assistance from medical team.

D. The patient is demonstrating symptoms of hyperventilation. Offer reassurance, administer oxygen.

258. **What is not a cause of postural hypotension?**

- a) The time of day
- b) **Lack of exercise**
- c) Temperature
- d) Recent food intake

259. **Mrs Red's doctor is suspecting an aortic aneurysm after her chest x-ray. Which of the most common type of aneurysm?**

- A) cerebral
- B) **abdominal**
- C) femoral
- D) thoracic



260. **A nurse is advised one hour vital charting of a patient, how frequently it should be recorded?**

- a) Every 3 hours
- b) Every shift
- c) Whenever the vital signs show deviations from normal
- d) **Every one hour**

261. **Why are support stockings used?**

- A. To aid mobility
- B. To promote arterial flow
- C. To aid muscle strength
- D. **To promote venous flow**

262. **Anti-embolic stockings are an effective means of reducing the potential of developing a deep vein thrombosis because:**

- A) They promote arterial blood flow.
- B) **They promote venous blood flow.**
- C) They reduce the risk of postoperative swelling.
- D) They promote lymphatic fluid flow, and drainage

263. **In DVT TEDS stockings affect circulation by:**

- a) **increasing blood flow velocity in the legs by compression of the deep venous system - thromboembolism-deterrent hose**
- b) decreasing blood flow velocity in legs by compression of the deep venous system

264. You are looking after a 75 year old woman who had an abdominal hysterectomy 2 days ago. What would you do reduce the risk of her developing a deep vein thrombosis (DVT)?
- A. Give regular analgesia to ensure she has adequate pain relief so she can mobilize as soon as possible. Advise her not to cross her legs
  - B. Make sure that she is fitted with properly fitting antiembolic stockings & that are removed daily
  - C. Ensure that she is wearing antiembolic stockings & that she is prescribed prophylactic anticoagulation & is doing hourly limb exercises
  - D. Give adequate analgesia so she can mobilize to the chair with assistance, give subcutaneous low molecular weight heparin as prescribed. Make sure that she is wearing antiembolic stockings

265. A patient is being discharged from the hospital after having coronary artery bypass graft (CABG). Which level of the health care system will best serve the needs of this patient at this point?

- a) Primary care
- b) Secondary care
- c) Tertiary care
- d) Public health care

266. People with blood group A are able to receive blood from the following:

- a) Group A only
- b) Groups AB or B
- c) Groups A or O
- d) Groups A, B or O

267. Which finding should the nurse report to the provider prior to a magnetic resonance imaging MRI?

- A. History of cardiovascular disease
- B. Allergy to iodine and shellfish
- C. Permanent pacemaker in place
- D. Allergy to dairy products

268. How many phases of korotkoff sounds are there?

- A. 3
- B. 4
- C. 5
- D. 6

269. What is the name given to a decreased pulse rate or heart rate?

- a) Tachycardia
- b) Hypotension
- c) **Bradycardia**
- d) Arrhythmia

**270. A patient puts out his arm so that you can take his blood pressure. What type of consent is this?**

- a) Verbal
- b) Written
- c) **Implied**
- d) None of the above, consent is not required.

**271. Which finding should the nurse report to the provider to a magnetic resonance imaging MRI?**

- a) History of cardiovascular disease
- b) Allergy to iodine and shellfish
- c) **Permanent pacemaker in place**
- d) Allergy to dairy products

**272. Which of the following is the most common aneurysm site?**

- a) Hepatic Artery
- b) **Abdominal aorta**
- c) Renal arch
- d) Circle of Wills

**273. CVP line measures?**

- a) **Pressure in right atrium**
- b) Pulmonary arteries
- c) Left ventricle
- d) Vena cava

**274. Mrs Smith has been assessed to have a cardiac arrest after anaphylactic reaction to a medication. Cardiopulmonary Resuscitation (CPR) was started immediately. According to the Resuscitation Council UK, which of the following statements is true?**

- a.) Intramuscular route administration of adrenaline is always recommended during cardiac arrest after anaphylactic reaction.
- b.) **Intramuscular route for adrenaline is not recommended during cardiac arrest after anaphylactic reaction.**
- c.) Adrenaline can be administered intradermally during cardiac arrest after anaphylactic reaction.
- d.) None of the Above

275. The patient is being discharged from the hospital after having a coronary artery bypass graft (CABG). Which level of the health care system will best serve the needs of this patient at this point?

- a) Primary care.
- b) Secondary care.
- c) Tertiary care.
- d) Public health care.

276. A patient is prescribed methformin 1 000mg twice a day for his diabetes. While taking with the patient he states "I never eat breakfast so I take ½ tablet at lunch and a whole tablet at supper because I don't want my blood sugar to drop." As his primary care nurse you:

- a) Tell him he has made a good decision and to continue
- b) Tell him to take a whole tablet with lunch and with supper
- c) Tell him to skip the morning dose and just take the dose at supper
- d) Tell him to take one tablet in the morning and one tablet in the evening as ordered.

277. The nurse is caring for a diabetic patient and when making rounds, notices that the patient is trembling and stating they are dizzy. The next action by the nurse would be:

- a) Administer patient's scheduled Metformin
- b) Give the patient a glass of orange juice
- c) Check the patient's blood glucose
- d) Call the doctor

278. Common signs and symptoms of a hypoglycaemia exclude:

- a) Feeling hungry
- b) Sweating
- c) Anxiety or irritability
- d) Blurred vision
- e) Ketoacidosis

279. Hypoglycaemia in patients with diabetes is more likely to occur when the patients take: (Select x 3 correct answers)

- a) Insulin
- b) Sulphonylureas
- c) Prandial glucose regulators
- d) Metformin

280. What are the contraindications for the use of the blood glucose meter for blood glucose monitoring?

- a) The patient has a needle phobia and prefers to have a urinalysis.

- b) If the patient is in a critical care setting, staff will send venous samples to the laboratory for verification of blood glucose level.
- c) If the machine hasn't been calibrated
- d) If peripheral circulation is impaired, collection of capillary blood is not advised as the results might not be a true reflection of the physiological blood glucose level.

281. What would you do if a patient with diabetes and peripheral neuropathy requires assistance cutting his toe nails?

- a) Document clearly the reason for not cutting his toe nails and refer him to a chiropodist.
- b) Document clearly the reason for not cutting his nails and ask the ward sister to do it.
- c) Have a go and if you run into trouble, stop and refer to the chiropodist.
- d) Speak to the patient's GP to ask for referral to the chiropodist, but make a start while the patient is in hospital.

282. For an average person from UK who has non-insulin dependent diabetes, how many servings of fruits and vegetables per day should they take?

- a) 1 serving
- b) 3 servings
- c) 5 servings
- d) 7 servings

283. Common causes for hyperglycaemia include:

- a) Not eating enough protein
- b) Eating too much carbohydrate
- c) Over-treating a hypoglycaemia
- d) Stress
- e) Infection (for example, colds, bronchitis, flu, vomiting, diarrhoea, urinary infections, and skin infections)

284. Most of the symptoms are common in both type1 and type 2 diabetes. Which of the following symptom is more common in typ1 than type2?

- a) Thirst
- b) Weight loss
- c) Poly urea
- d) Ketones

285. Alone, metformin does not cause hypoglycaemia (low blood sugar). However, in rare cases, you may develop hypoglycaemia if you combine metformin with:

- a) a poor diet
- b) strenuous exercise
- c) excessive alcohol intake
- d) other diabetes medications

286. The nurse is caring for a diabetic patient and when making rounds, notices that the patient is trembling and stating they are dizzy. The next action by the nurse would be:

- a) Administer patient's scheduled Metformin
- b) Give the patient a glass of orange juice
- c) Check the patient's blood glucose
- d) Call the doctor

287. When developing a program offering for patients who are newly diagnosed with diabetes, a nurse case manager demonstrates an understanding of learning styles by:

- a) Administering a pre- and post test assessment.
- b) Allowing patient's time to voice their opinions.
- c) Providing a snack with a low glycaemic index.
- d) Utilizing a variety of educational materials.

288. Mr Cross informed you of how upset he was when you commented on his diabetic foot during your regular home visit. He is considering to see another tissue viability nurse. How will you best respond to him?

- A. Apologise for the comments made
- B. Tell him of his overreaction
- C. Explain that his condition will make him over-sensitive to a lot of things
- D. Apologise and tell him to deal with the event lightly

289. You are preparing to consider a Tuberculin (Mantoux) skin test to a client suspected of having TB. The nurse knows that the test will reveal which of the following?

- A) How long the client has been infected with TB
- B) Active TB infection
- C) Latent TB infection
- D) Whether the client has been infected with TB bacteria

290. How do we handle a specimen container labelled with a yellow hazard sticker?

- a) Wear gloves and apron, mark it high risk and send the specimen to the laboratory with your other specimens
- b) Wear gloves and apron, mark it high risk and send the specimen to the laboratory with your other specimens

- c) Wear gloves and apron, inform the infection control team and complete a datix form
- d) Wear gloves and apron, place specimen in a blue bag & complete a datix form

**291. When collecting an MSU from a male patient, what should they do prior to the specimen being collected?**

- a) Clean the meatus and catch a specimen from the last of the urine voided
- b) Clean the meatus and catch a specimen from the first stream of urine (approx. 30mls)
- c) **Clean the meatus and catch a specimen of the urine midstream**
- d) Ask the patient to void into a bottle and pour urine specimen into the specimen container.

**292. How do you ensure the correct blood to culture ratio when obtaining a blood culture specimen from an adult patient?**

- a) **Collect at least 10 mL of blood**
- b) Collect at least 5 mL of blood.
- c) Collect blood until the specimen bottle stops filling.
- d) Collect as much blood as the vein will give you

**293. If blood is being taken for other tests, and a patient requires collection of blood cultures, which should come first to reduce the risk of contamination?**

- a) **Inoculate the aerobic culture first**
- b) Take the other blood tests first.
- c) Inoculate the anaerobic culture first.
- d) The order does not matter as long as the bottles are clean

**294. Which of the following techniques is advisable when obtaining a urine specimen in order to minimize the contamination of a specimen?**

- a) **Clean around the urethral meatus prior to sample collection and get a midstream/clean catch urine specimen.**
- b) Clean around the urethral meatus prior to sample collection and collect the first portion of urine as this is where the most bacteria will be.
- c) Do not clean the urethral meatus as we want these bacteria to analyse as well.
- d) Dip the urinalysis strip into the urine in a bedpan mixed with stool

**295. When dealing with a patient who has a biohazard specimen, how will you ensure proper disposal? Select which does not apply:**

- a) the specimen must be labelled with a biohazard

b) the specimen must be labelled with danger of infection

c) it must be in a double self-sealing bag

d) it must be transported to the laboratory in a secure box with a fastenable lid

296. What action would you take if a specimen had a biohazard sticker on it?

a) Double bag it, in a self-sealing bag, and wear gloves if handling the specimen.

b) Wear gloves if handling the specimen, ring ahead and tell the laboratory the sample is on its way.

c) Wear goggles and underfill the sample bottle.

d) Wear appropriate PPE and overfill the bottle.

297. How do we handle a specimen container labelled with a yellow hazard sticker?

A) Wear gloves and apron and inform the laboratory that you are sending the specimen.

B) Wear gloves and apron, mark it high risk and send the specimen to the laboratory with your other specimens

C) Wear gloves and apron, Inform the infection control team and complete a datix form.

D) Wear gloves and apron, place specimen in a blue bag & complete a datix form.

298. You are caring for a patient who is known to have dementia. What particular issues should you consider prior to discharge.

a) \*You involve in his care: Independent Mental Capacity Advocacy Service (Mental Capacity Act 2005)

b) \*You involve other support services in his discharge: The hospital discharge team, social services, the mental health team

299. Which of the major theories of aging suggest that older adults may decelerate the aging process?

a) Disengagement theory

b) Activity theory

c) Immunology theory

d) Genetic theory

300. Which of the following is a guiding principle for the nurse in distinguishing mental disorders from the expected changes associated with aging

a) A competent clinician can readily distinguish mental disorders from the expected changes associated with aging

b) Older people are believed to be more prone to mental illness than young people

c) The clinical presentation of mental illness in older adults differs from that in other age groups

- d) When physical deterioration becomes a significant feature of an elder's life, the risk of comorbid psychiatric illness arises.

**301. A normal sign of aging in the renal system is**

- a) Intermittent incontinence
- b) Concentrated urine
- c) Microscopic hematuria
- d) A decreased glomerular filtration rate

**302. A 76 year old man who is a resident in an extended care facility is in the late stages of Alzheimer's disease. He tells his nurse that he has sore back muscles from all the construction work he has been doing all day. Which response by the nurse is most appropriate?**

- a) "you know you don't work in construction anymore"
- b) "What type of motion did you do to precipitate this soreness?"
- c) "You're 76 years old & you've been here all day. You don't work in construction anymore."
- d) "Would you like me to rub your back for you?"

**303. How should be the surrounding area of a patient with dementia?**

- A) Increased stimuli
- B) Creative environment
- C) Restrict activities

**304. An 86 year old male with senile dementia has been physically abused & neglected for the past two years by his live in caregiver. He has since moved & is living with his son & daughter-in-law. Which response by the client's son would cause the nurse great concern?**

- a) "How can we obtain reliable help to assist us in taking care of Dad? We can't do it alone."
- b) "Dad used to beat us kids all the time. I wonder if he remembered that when it happened to him?"
- c) "I'm not sure how to deal with Dad's constant repetition of words."
- d) "I plan to ask my sister & brother to help my wife & me with Dad on the weekends."

**305. Knowing the difference between normal age- related changes & pathologic findings, which finding should the nurse identify as pathologic in a 74 year old patient?**

- a) Increase in residual lung volume

- b) Decrease in sphincter control of the bladder
  - c) **Increase in diastolic BP**
  - d) Decreased response to touch, heat & pain.
306. Which of the following is a behavioural risk factor when assessing the potential risks of falling in an older person?
- a) **Poor nutrition/fluid intake**
  - b) Poor heating
  - c) Foot problems
  - d) Fear of falling
307. What medications would most likely increase the risk for fall?
- a) Loop diuretic
  - b) **Hypnotics**
  - c) Betablockers
  - d) Nsaid
308. Among the following drugs, which does not cause falls in an elderly?
- A. Diuretics
  - B. NSAIDS**
  - C. Beta blockers
  - D. Hypnotics
309. Mr Bond, 72 years old, complains of difficulty of chewing his food. He normally wears upper dentures daily. On assessment, you noticed some signs of **gingivitis**. Which of the following signs will you expect?
- a) redness of soft palate and tissues surrounding the teeth**
  - b) haemo-serous discharges around the gums
  - c) **loosening of teeth**
  - d) presence of pockets deep in the gums
310. Mr Bond also shared with you that his gums also bleed during brushing. Which of the following statement will best explain this?
- a) lack of vitamin C in his diet
  - b) **he is brushing too hard**
  - c) he is not using proper toothbrush to remove the plaque**
  - d) he is flossing wrongly
311. What are the principles of communicating with a patient with delirium?
- a) **Use short statements and closed questions in a well lit, quiet, familiar environment.**

- b) Use short statements and open questions in a well lit, quiet, familiar environment
- c) Write down all questions for the patient to refer back to.
- d) Communicate only through the family using short statements and closed questions.

312. Why is pyrexia not evident in the elderly?

- A. Due to lesser body fat
- B. Due to immature T cells**
- C. Due to aged hypothalamus
- D. Due to biologic changes

313. Which of the following is a sign of dehydration in the elderly?

- a) diminished skin turgor**
- b) hypertension
- c) anxiety attacks
- d) pyrexia

314. In a community hospital, an elderly man approaches you and tells you that his neighbour has been stealing his money, saying "sometimes I give him money to buy groceries but he didn't buy groceries and he kept the money" what is your best course of action for this?

- A) Raise a safeguarding alert**
- B) Just listen but don't do anything
- C) Ignore the old man, he is just having delusions
- D) Refer the old man to the community clergy who is giving him spiritual support

315. Which is not an appropriate way to care for patients with Dementia/Alzheimer's?

- A. Ensure people with dementia are excluded from services because of their diagnosis, age, or any learning disability.**
- B. Encourage the use of advocacy services and voluntary support.
- C. Allow people with dementia to convey information in confidence.
- D. Identify and wherever possible accommodate preferences (such as diet, sexuality and religion).

316. Barbara, an elderly patient with dementia, wishes to go out of the hospital. What will be your appropriate action?

- A) Call the police, make sure she does not leave**
- B) Encourage the patient to stay for his well being**
- C) Inform the police to arrest the patient
- D) Allow her to leave, she is stable and not at risk of anything

317. Conditions **producing orthostatic hypotension** in the elderly:

- A) Aortic stenosis
- B) Arrhythmias
- C) Diabetes
- D) Pernicious anaemia
- E) Advanced heart failure
- F) All of the above

318. An 83-year old lady just lost her husband. Her brother visited the lady in her house. He observed that the lady is acting okay but it is obvious that she is depressed. 3 weeks after the husband's death, the lady called her brother crying and was saying that her husband just died. She even said, "I can't even remember him saying he was sick." When the brother visited the lady, she was observed to be well physically but was irritable and claims to have frequent urination at night and she verbalizes that she can see lots of rats in their kitchen. Based on the manifestations, as a nurse, what will you consider as a diagnosis to this patient?

- A) urinary tract infection leading to delirium
- B) delayed grieving with dementia

319. Angel, 52 years old lost her husband due to some disease. 4 weeks later, she calls her mother and says that, yesterday my husband died...I didn't know that he was sick...I can't sleep and I see rats and mites in the kitchen. What is Angel's condition?

- A) She can't adjust without her husband
- B) Late grievance with signs of dementia
- C) Alzheimers with delirium

320. Why are elderly prone to postural hypotension? Select which **does not** apply:

- A. The baroreflex mechanisms which control heart rate and vascular resistance decline with age.
- B. Because of medications and conditions that cause hypovolaemia.
- C. Because of less exercise or activities.
- D. Because of a number of underlying problems with BP control.

321. Why should healthcare professionals take extra care when washing and drying an elderly patient's skin?

- A) As the older generation deserve more respect and tender loving care (TLC).
- B) As the skin of an elderly person has reduced blood supply, is thinner, less elastic and has less natural oil. This means the skin is less resistant to shearing forces and wound healing can be delayed.
- C) All elderly people lose dexterity and struggle to wash effectively so they need support with personal hygiene.

- D) As elderly people cannot reach all areas of their body, it is essential to ensure all body areas are washed well so that the colonization of Gram-positive and negative micro-organisms on the skin is avoided.

**322. Why is pyrexia not always evident in the elderly?**

- A. Due to immature T cells
- B. Due to mature T cells
- C. Due to immature D cells
- D. Due to mature D cells

**323. Why constipation occurs in old age?**

- A) Anorexia and weight loss
- B) Decreased muscle tone and peristalsis
- C) Increased mobility
- D) Increased absorption in colon

**324. You are looking after an emaciated 80-year old man who has been admitted to your ward with acute exacerbation of chronic obstructive airways disease (COPD). He is currently so short of breath that it is difficult for him to mobilize. What are some of the actions you take to prevent him developing a pressure ulcer?**

- A) He will be at high risk of developing a pressure ulcer so place him on a pressure relieving mattress
- B) Assess his risk of developing a pressure ulcer with a risk assessment tool. If indicated, procure an appropriate pressure –relieving mattress for his bed & cushion for his chair. Reassess the patient's pressure areas at least twice a day & keep them clean & dry. Review his fluid & nutritional intake & support him to make changes as indicated.
- C) Assess his risk of developing a pressure ulcer with a risk assessment tool & reassess every week. Reduce his fluid intake to avoid him becoming incontinent & the pressure areas becoming damp with urine
- D) He is at high risk of developing a pressure ulcer because of his recent acute illness, poor nutritional intake & reduced mobility. By giving him his prescribed antibiotic therapy, referring him to the dietician & physiotherapist, the risk will be reduced.

**325. You are looking after a 76-year old woman who has had a number of recent falls at home. What would you do to try & ensure her safety whilst she is in hospital?**

- A) Refer her to the physiotherapist & provide her with lots of reassurance as she has lost a lot of confidence recently
- B) Make sure that the bed area is free of clutter. Place the patient in a bed near the nurse's station so that you can keep an eye on her. Put her on an hourly

toileting chart. obtain lying & standing blood pressures as postural hypotension may be contributing to her falls

- C) Make sure that the bed area is free of clutter & that the patient can reach everything she needs, including the call bell. Check regularly to see if the patient needs assistance mobilizing to the toilet. ensure that she has properly fitting slippers & appropriate walking aids
- D) Refer her to the community falls team who will assess her when she gets home

**326. You are looking after a 75 year old woman who had an abdominal hysterectomy 2 days ago. What would you do reduce the risk of her developing a deep vein thrombosis (DVT)?**

- A) Give regular analgesia to ensure she has adequate pain relief so she can mobilize as soon as possible. Advise her not to cross her legs
- B) Make sure that she is fitted with properly fitting antiembolic stockings & that are removed daily
- C) Ensure that she is wearing antiembolic stockings & that she is prescribed prophylactic anticoagulation & is doing hourly limb exercises
- D) Give adequate analgesia so she can mobilize to the chair with assistance, give subcutaneous low molecular weight heparin as prescribed. Make sure that she is wearing antiembolic stockings

**327. Fiona a 70 year old has recently been diagnosed with type 2 diabetes. You have EC devised a care plan to meet her nutritional needs. However, you have noted that she has poor fitting dentures. Which of the following is the least likely risk to the service user?**

- a) Malnutrition
- b) Hyperglycemia
- c) Dehydration
- d) Hypoglycaemia

**328. What is the most common cause of hypotension in elderly?**

- a) Decreased response in adrenaline & noradrenaline
- b) Atheroma changes in vessel walls
- c) hyperglycaemia
- d) Age

**329. What is an intermediate care home?**

- a) It is the day-to-day health care given by a health care provider.
- b) It includes a range of short-term treatment or rehabilitative services designed to promote independence.
- c) It is a system of integrated care.
- d) It is a means of organising work, that is patient allocation.

**330. What is not included in the care package in a nursing home?**

- a) Laundry

- b) Food
- c) Nursing Care
- d) Social Activities**

**331. The nurse cares for an elderly patient with moderate hearing loss. The nurse should teach the patient's family to use which of the following approaches when speaking to the patient?**

- a) Raise your voice until the patient is able to hear you.
- b) Face the patient and speak quickly using a high voice.
- c) Face the patient and speak slowly using a slightly lowered voice.**
- d) Use facial expressions and speak as you would formally

**332. Your nurse manager approaches you in a tertiary level old age home where complex cases are admitted, and she tells you that today everyone should adopt task - oriented nursing to finish the tasks by 10 am what's your best action**

- A) Discuss with the manager that task oriented nursing may ruin the holistic care that we provide here in this tertiary level.**
- B) Ask the manager to re-consider the time bound, make sure that all staffs are informed about task oriented nursing care

**333. A patient with dementia is mourning and pulling the dress during night what do you understand from this?**

- A) Patient is incontinent**
- B) Patient is having pain
- C) Patient has medication toxicity.

**334. An elderly client with dementia is cared by his daughter. The daughter locks him in a room to keep him safe when she goes out to work and not considering any other options. As a nurse what is your action?**

- a) Explain this is a restraint. Urgently call for a safe guarding and arrange a multi-disciplinary team conference**
- b) Do nothing as this is the best way of keeping him safe
- c) Call police, social services to remove client immediately and refer to safeguarding
- d) Explain this is a restraint and discuss other possible options

**335. In a community setting, an elderly patient reported to you that he gives shopping money to his neighbours but failed to bring groceries on frequent occasions. What is your best response on this situation?**

- a) Confront the neighbour
- b) Ignore, maybe he is very old and does not think clearly

- c) Fill up a raising a concern/ safeguarding form, and escalate
  - d) ask patient to report neighbour to police
336. Which of the following displays the proper use of Zimmer frame?
- a) using a 1 point gait
  - b) using a 2 point gait
  - c) using a 3 point gait
  - d) using a 4 point gait
337. The client advanced his left crutch first followed by the right foot, then the right crutch followed by the left foot. What type of gait is the client using?
- A) Swing to gait
  - B) Three point gait
  - C) Four point gait
  - D) Swing through gait
338. Nurse is teaching patient about crutch walking which is incorrect?
- a) Take long strides
  - b) Take small strides
  - c) Instruct to put weight on hands
339. After instructing the client on crutch walking technique, the nurse should evaluate the client's understanding by using which of the following methods?
- a) Have client explain procedure to the family
  - b) Achievement of 90 on written test
  - c) Explanation
  - d) Return demonstration
340. A nurse is caring for a patient with canes. After providing instruction on proper cane use, the patient is asked to repeat the instructions given. Which of the following patient statement needs further instruction?
- a) 'The hand opposite to the affected extremity holds the cane to widen the base of support & to reduce stress on the affected limb.'
  - b) as the cane is advanced, the affected leg is also moved forward at the same time'
  - c) 'when the unaffected extremity begins the swing phase, the client should bear down on the cane'
  - d) To go up the stairs, place the cane & affected extremity down on the step. Then step down the unaffected extremity'

341. Nurses assume responsibility on patient with cane. Which of the following is the nurse's **topmost priority** in caring for a patient with cane?
- a) Mobility
  - b) Safety**
  - c) Nutrition
  - d) Rest periods
342. To promote stability for a patient using walkers, the nurse should instruct the patient to place his hands at:
- a) The sides of the walker
  - b) The hips
  - c) The hand grips**
  - d) The tips
343. A client is ambulating with a walker. The nurse corrects the walking pattern of the patient if he does which of the following?
- a) The patient walks first & then lifts the walker**
  - b) The walker is held on the hand grips for stability
  - c) The patient's body weight is supported by the hands when advancing his weaker leg.**
  - d) All of these
344. The nurse should adjust the walker at which level to promote safety & stability?
- a) Knee
  - b) Hip**
  - c) Chest
  - d) Armpit
345. The nurse is caring for an immobile client. The nurse is promoting interventions to prevent foot drop from occurring. Which of the following is least likely a cause of foot drop?
- a) Bed rest**
  - b) Lack of exercise
  - c) Incorrect bed positioning
  - d) Bedding weight that forces the toes into plantar flexion**
346. The nurse should consider performing preparatory exercises on which muscle to prevent flexion or buckling during crutch walking?
- a) Shoulder depressor muscles
  - b) Forearm extensor muscles**
  - c) Wrist extensor muscles
  - d) Finger & thumb flexor muscles

347. The nurse is measuring the crutch using the patient's height. How many inches should the nurse subtract from the patient's height to obtain the approximate measurement?

- a) 10 inches
- b) 16 inches
- c) 9 inches
- d) 5 inches

348. The most advanced gait used in crutch walking is:

- a) Four point gait
- b) Three point gait
- c) Swing to gait
- d) Swing through gait

349. In going up the stairs with crutches, the nurse should instruct the patient to:

- A) Advance the stronger leg first up to the step then advance the crutches & the weaker extremity.
- B) Advance the crutches to the step then the weaker leg is advanced after. The stronger leg then follows.
- C) Advance both crutches & lift both feet & swing forward landing next to crutches.
- D) Place both crutches in the hand on the side of the affected extremity

350. The patient can be selected with a crutch gait depending on the following apart from:

- A) Patient's physical condition
- B) Arm & trunk strength
- C) Body balance
- D) Coping mechanism

351. Proper technique to use walker<zimmers frame>

- a) move 10 feet, take small steps
- b) move 10feet,take large wide steps
- c) move 12feet
- d transform weight to walker and walk

**352. When using crutches, what part of the body should absorb the patient's weight?**

- A. Armpits
- B. Hands**
- C. Back
- D. Shoulders

**353. What a patient should not do when using zimmer frame**

- A) it can be used outside
- B) don't carry any other thing with walker
- C) push walker forward when using**
- D) slide walker forward

**354. What should be taught to a client about use of zimmer frame**

- A) **move affected leg first**
- B) move unaffected leg
- C) move both legs together**

**355. The nurse is giving the client with a left cast crutch walking instructions using the three point gait. The client is allowed touchdown of the affected leg. The nurse tells the client to advance the:**

- a) Left leg and right crutch then right leg and left crutch
- b) Crutches and then both legs simultaneously
- c) Crutches and the right leg then advance the left leg**
- d) **Crutches and the left leg then advance the right leg**

**356. Which layer of the skin contains blood and lymph vessels. Sweat and sebaceous glands?**

- a) Epidermis
- b) Dermis**
- c) Subcutaneous layer
- d) All of the above

**357. What is abduction?**

- a) Division of the body into front and back
- b) Movement of a body parts towards the body's midline
- c) Division of the body into left and right
- d) Movement of body part away from the body's midline**

**358. What is the clinical benefit of active ankle movements?**

- a) To assist with circulation
- b) To lower the risk of a DVT
- c) To maintain joint range
- d) All of the above

359. In the context of assessing risks prior to moving and handling, what does T-I-L-E stand for?

- a) Task – individual – lift – environment
- b) Task – intervene – load – environment
- c) Task – intervene – load – equipment
- d) Task – individual – load – environment

360. In Spinal cord injury patients, what is the most common cause of autonomic dysreflexia ( a sudden rise in blood pressure)?

- a) Bowel obstruction
- b) Fracture below the level of the spinal lesion
- c) Pressure sore
- d) \*Urinary obstruction

361. A client with a right arm cast for fractured humerus states, “I haven’t been able to straighten the fingers on the right hand since this morning.” What action should the nurse take?

- a) Assess neurovascular status to the hand
- b) Ask the client to massage the fingers
- c) Encourage the client to take the prescribed analgesic
- d) Elevate the arm on a pillow to reduce oedema

362. How do the structures of the human body work together to provide support and assist in movement?

- a) The skeleton provides a structural framework. This is moved by the muscles that contract or extend and in order to function, cross at least one joint and are attached to the articulating bones.
- b) The muscles provide a structural framework and are moved by bones to which they are attached by ligaments.
- c) The skeleton provides a structural framework; this is moved by ligaments that stretch and contract.
- d) The muscles provide a structural framework, moving by contracting or extending, crossing at least one joint and attached to the articulating bones.

363. What does ‘muscle atrophy’ mean?

- a) Loss of muscle mass
- b) A change in the shape of muscles
- c) Disease of the muscle

364. Approximately how long is the spinal cord in an adult?
- a) 30 cm
  - b) 45 cm
  - c) 60 cm
  - d) 120 cm
365. Carpal tunnel syndrome is caused by compression of which nerve:
- a) Median nerve
  - b) Axillary nerve
  - c) Ulnar nerve
  - d) Radial nerve
366. The most commonly injured carpal bone is:
- a) the scaphoid bone
  - b) the triquetral bone
  - c) the pisiform bone
  - d) the hamate bone
367. Client had fractured hand and being cared at home requiring analgesia. The medication was prescribed under PGD. Which of the following statements are correct relating to this:
- a) A PGD can be delegated to student nurse who can administer medication with supervision
  - b) PGD's cannot be delegated to anyone
  - c) This type of prescription is not made under PGD
  - d) This can be delegated to another RN who can administer in view of a competent person
368. Patient is post of repair of tibia and fibula possible signs of compartment syndrome include
- a) Numbness and tingling
  - b) Cool dusky toes
  - c) Pain
  - d) Toes swelling
  - e) All of the above
369. Patient has tibia fibula fracture. Which one of the following is not a symptom of compartment syndrome
- a) Pain not subsiding even after giving epidural analgesia
  - b) Nausea and vomiting
  - c) Tingling and numbness of the lower limb

d) Cold extremities

**370. A Chinese woman has been admitted with fracture of wrist. When you are helping her undress, you notice some bruises on her back and abdomen of different ages. You want to talk to her and what is your action**

- a) Ask her husband about the bruises
- b) Ask her son/ daughter to translate
- c) Arrange for interpreter to ask questions in private
- d) Do not carry any assessment and document this is not possible as the client cannot speak English

**371. What is the clinical benefit of active ankle movements?**

- A. To assist with circulation
- B. To lower the risk of a DVT
- C. To maintain joint range
- D. All of the above

**372. It is unsafe for a spinal tap to be undertaken if the patient:**

- a) Has bacterial meningitis
- b) Papilloedema
- c) Intracranial mass is suspected
- d) Site skin infection

**373. How do you test the placement of an enteral tube?**

- A. Monitoring bubbling at the end of the tube
- B. Testing the acidity/alkalinity of aspirate using blue litmus paper
- C. Interpreting absence of respiratory distress as an indicator of correct positioning
- D. Have an abdominal x-ray

**374. During enteral feeding in adults, at what degree angle should the patient be nursed at to reduce the risk of reflux and aspiration?**

- A) 25
- B) 35
- C) 45
- D) 55

**375. What is the use of protected meal time?**

- a) Patient get protection from visitors
- b) Staff get enough time to have their bank
- c) To give personal hygiene to patients who are confused

- d) Patients get enough time to eat food without distractions while staff focus on people who needs help with eating

376. What is the best way to prevent who is receiving an enteral feed from aspirating?

- a) Lie them flat
- b) Sit them at least 45-degree angle
- c) Tell them to lie in their side
- d) Check their oxygen saturations

377. Approximately how many people in the UK are malnourished?

- a) 1 million
- b) 3 million
- c) 5 million
- d) 7 million

378. How can patients who need assistance at meal times be identified?

- a) A red sticker
- b) A colour serviette
- c) A red tray
- d) Any of the above

379. Which of the following is no longer a recommended method of mouth care?

- a) Chlorhexidine solution and foam sticks
- b) Sodium bicarbonate
- c) Normal saline mouth wash
- d) Glycerine and lemon swabs

380. Which of the following is not a cause of gingival bleeding?

- a) Lifestyle
- b) Vitamin deficiency (Vitamin C and K)
- c) Vigorous brushing of teeth
- d) Intake of blood thinning medication (warfarin, aspirin, and heparin)

381. What specifically do you need to monitor to avoid complications & ensure optimal nutritional status in patients being enterally fed?

- a) Daily urinalysis, ECG, Protein levels and arterial pressure
- b) Assess swallowing, patient choice, fluid balance, capillary refill time
- c) Eye sight, hearing, full blood count, lung function and stoma site
- d) Blood glucose levels, full blood count, stoma site and body weight

382. A patient is recovering from surgery has been advanced from a clear diet to a full liquid diet. The patient is looking forward to the diet change because he has been "bored" with the clear liquid diet. The nurse should offer which full liquid item to the patient
- a) Custard
  - b) Black Tea
  - c) Gelatin
  - d) Ice pop
383. According to recent UK research, what is the recommended amount of vegetables and fruits to be consumed per day?
- a) 3 portions per serving
  - b) 5 portions per serving
  - c) 7 portions per serving
  - d) 4 portions per serving
384. The nurse is preparing to change the parenteral nutrition (PN) solution bag & tubing. The patient's central venous line is located in the right subclavian vein. The nurse ask the client to take which essential action during the tubing change?
- a) Take a deep breath, hold it, & bear down
  - b) Breathe normally
  - c) Exhale slowly & evenly
  - d) Turn the head to the right
385. A 27-year old adult male is admitted for treatment of Crohn's disease. Which information is most significant when the nurse assesses his nutritional health?
- a) Facial rubor
  - b) Dry skin
  - c) Bleeding gums
  - d) Anthropometric measurements
386. If the prescribed volume is taken, which of the following type of feed will provide all protein, vitamins, minerals and trace elements to meet patient's nutritional requirements?
- a) Protein shakes/supplements
  - b) Energy drink
  - c) Mixed fat and glucose polymer solutions/powder
  - d) Sip feed

387. A patient has been admitted for nutritional support and started receiving a hyperosmolar feed yesterday. He presents with diarrhea but no pyrexia. What is likely to be cause?

- a) An infection
- b) Food poisoning
- c) Being in hospital
- d) The feed

388. Your patient has a bulky oesophageal tumor and is waiting for surgery. When he tries to eat, food gets stuck and gives him heart burn. What is the most likely route that will be chosen to provide him with the nutritional support he needs?

- a) Feeding via Radiologically inserted Gastostomy (RIG)
- b) Nasogastric tube feeding
- c) Feeding via a Percutaneous Endoscopic Gastrostomy (PEG)
- d) Continue oral

389. Which of the following medications are safe to be administered via a naso-gastric tube?

- a) Drugs that can be absorbed via this route, can be crushed and given diluted or dissolved in 10-15 ml of water
- b) Enteric-coated drugs to minimize the impact of gastric irritation
- c) A cocktail of all medications mixed together, to save time and prevent fluid over loading the patient
- d) Any drugs that can be crushed

390. An overall risk of malnutrition of 2 or higher signifies:

- a) Low risk of malnutrition
- b) Medium risk of malnutrition
- c) High risk of malnutrition

391. One of the government initiative in promoting good healthy living is eating the right and balanced food. Which of the following can achieve this?

- a) 24/7 exercise programme
- b) 5-a-day fruits and vegetable portions
- c) low calorie diet
- d) high protein diet

392. **Mr Bond's daughter rang and wanted to visit him. She told you of her diarrhoea and vomiting in the last 24 hours. How will you best respond to her about visiting Mr Bond?**
- a) allow her to visit and use alcohol gel before contact with him
  - b) visit him when she feels better
  - c) visit him when she is symptom free after 48 hours
  - d) allow her to visit only during visiting times only
393. **An overall risk of malnutrition of 2 or higher signifies:**
- a) Low risk of malnutrition
  - b) Medium risk of malnutrition
  - c) High risk of malnutrition
394. **Enteral feeding patient checks patency of tube placement by: x 2 correct answers**
- a) Pulling on the tube and then pushing it back in place
  - b) Aspirating gastric juice and then checking for pH<4
  - c) Infusing water or air and listening for gurgles
  - d) X-ray
395. **The client reports nausea and constipation. Which of the following would be the priority nursing action?**
- a) Complete an abdominal assessment
  - b) Administer an anti-nausea medication
  - c) Notify the physician
  - d) Collect a stool sample
396. **What specifically do you need to monitor to avoid complications and ensure optimal nutritional status in patients being enterally fed?**
- a) Blood glucose levels, full blood count, stoma site and bodyweight.
  - b) Eye sight, hearing, full blood count, lung function and stoma site.
  - c) Assess swallowing, patient choice, fluid balance, capillary refill time.
  - d) Daily urinalysis, ECG, protein levels and arterial pressure.
397. **What is the best way to prevent a patient who is receiving an enteral feed from aspirating?**
- a) Lie them flat.
  - b) Sit them at least at a 45° angle.
  - c) Tell them to lie on their side.

- d) Check their oxygen saturations.
398. Which check do you need to carry out before setting up an enteral feed via a nasogastric tube?
- a) That when flushed with red juice, the red juice can be seen when the tube is aspirated.
  - b) That air cannot be heard rushing into the lungs by doing the whoosh test
  - c) That the pH of gastric aspirate is  $<5.5$ , and the measurement on the NG tube is the same length as the time insertion.
  - d) That pH of gastric aspirate is  $>6.0$ , and the measurement on the NG tube is the same length as the time insertion
399. Which check do you need to carry out every time before setting up a routine enteral feed via a nasogastric tube?
- a) That when flushed with red juice, the red juice can be seen when the tube is aspirated
  - b) That air cannot be heard rushing into the lungs by doing the 'whoosh test'.
  - c) That the pH of gastric aspirate is  $<4$ , and the measurement on the NG tube is the same length as the time insertion
  - d) abdominal x-ray
400. Your patient has a bulky oesophageal tumour and is waiting for surgery. When he tries to eat, food gets stuck and gives him heartburn. What is the most likely route that will be chosen to provide him with the nutritional support he needs?
- a) Nasogastric tube feeding
  - b) Feeding via a percutaneous endoscopic gastrostomy (PEG)
  - c) Feeding via a radiologically inserted gastrostomy (RIG)
  - d) Continue oral food
401. Which of the following medications are safe to be administered via a nasogastric tube?
- a) Enteric coated drugs to minimize the impact of gastric irritation.
  - b) A cocktail of all medications mixed together, to save time and prevent fluid overloading the patient.
  - c) Any drugs that can be crushed.
  - d) Drugs that can be absorbed via this route, can be crushed and given diluted or dissolved in 10-15 ml of water
402. What specifically do you need to monitor to avoid complications and ensure optimal nutritional status in patients being enterally fed?

- a) Blood glucose levels, full blood count, stoma site and bodyweight
- b) Eye sight, hearing, full blood count, lung function and stoma site
- c) Assess swallowing, patient choice, fluid balance, capillary refill time
- d) Daily urinalysis, ECG, protein levels and arterial pressure

403. If a patient requires protective isolation, which of the following should you advise them to drink?

- a) Filtered water only
- b) Fresh fruit juice and filtered water
- c) Bottled water and tap water
- d) Long-life fruit juice and filtered water

404. A patient has been admitted for nutritional support and started receiving a hyperosmolar feed yesterday. He presents with diarrhoea but has no pyrexia. What is likely to be the cause?

- a) The feed
- b) An infection
- c) Food poisoning
- d) Being in hospital

405. Adam, 46 years old is of Jewish descent. As his nurse, how will you plan his dietary needs?

- a) Assume he strictly needs Jewish food
- b) Ask relatives to bring food from kosher market
- c) Ask a rabbi to help you plan
- d) Ask the patient about his diet preferences

406. An adult woman asks for the best contraception in view of her holiday travel to a diarrhoea prone areas. She is currently taking oral contraceptives. What advice will you give her?

- a) Tell her to abstain from having sex because of HIV
- b) Tell her to bring lots of contraceptives because it will be expensive
- c) Tell her to use other methods like condom because diarrhoea lessens the effects of OCP
- d) tell her to continue taking her usual contraceptives

407. Dehydration is of particular concern in ill health. If a patient is receiving IV fluid replacement and is having their fluid balance recorded, which of the following statements is true of someone said to be in "positive fluid balance"

- a) The fluid output has exceeded the input
- b) The doctor may consider increasing the IV drip rate
- c) The fluid balance chart can be stopped as "positive" means "good"

d) The fluid input has exceeded the output

408. The nurse is preparing to change the parenteral nutrition (PN) solution bag & tubing. The patient's central venous line is located in the right subclavian vein. The nurse asks the client to take which essential action during the tubing change?

- a) Breathe normally
- b) Turn the head to the right
- c) Exhale slowly & evenly
- d) Take a deep breath, hold it, & bear down

409. Obesity is one of the main problem. what might cause this?

- a) supermarket
- b) unequality
- c) low economic class

410. Constipation needs to be sort out during:

- a) planning
- b) assessment
- c) implementation
- d) evaluation

411. What may not be cause of diarrhea?

- a) colitis
- b) intestinal obstruction
- c) food allergy
- d) food poisoning

412. Perdue (2005) categorizes constipation as primary, secondary or iatrogenic. What could be some of the causes of iatrogenic constipation?

- A. Inadequate diet and poor fluid intake.
- B. Anal fissures, colonic tumours or hypercalcaemia.
- C. Lifestyle changes and ignoring the urge to defaecate.
- D. Antiemetic or opioid medication

413. A patient is to be subjected for surgery but the patient's BMI is low. Where will you refer the patient?

- A. Speech and Language Therapist
- B. Dietitian
- C. Chef
- D. Family member

414. **How can patients who need assistance at meal times be identified?**

- A. A red sticker
- B. A colour serviette
- C. A red tray
- D. Any of the above**

415. **Which of the following is no longer a recommended method of mouth care?**

- A. Chlorhexidine solution and foam sticks
- B. Sodium bicarbonate
- C. Normal saline mouth wash
- D. Glycerine and lemon swabs**

416. **Signs of denture related stomatitis**

- A. whiteness on the tongue
- B. patches of shiny redness on the cheek and tongue
- C. patches of shiny redness on the palette and gums**
- D. patches of shiny redness on the tongue

417. **Before a gastric surgery, a nurse identifies that the patients BMI is too low. Who she should contact to improve the patients' health before surgery**

- a) Gastro enterologist
- b) Dietitian**
- c) Family doc of patient
- d) Physio

418. **Which of the following is not a cause of gingival bleeding?**

- A. Vigorous brushing of teeth
- B. Intake of blood thinning medications (warfarin, aspirin, and heparin)
- C. Vitamin deficiency (Vitamins C and K)
- D. Lifestyle**

419. **A patient develops gingivitis after using an artificial denture. It is characterized by**

- a) White patches on tongue
- b) Red shiny patches on tongue
- c) Redshiny patches around the palate of tooth**

420. **Signs of denture-related stomatitis include all except:**

- A. Redness underneath the area where the dentures are placed
- B. Red sores at the corners of lips or on the roof of the mouth
- C. Presence of white patches inside the mouth
- D. Gingivitis

421. If a patient is experiencing dysphagia, which of the following investigations are they likely to have?

- a) Colonoscopy
- b) Gastroscopy
- c) Cystoscopy
- d) Arthroscopy

422. Signs and symptoms of early fluid volume deficit, except.

- A. Decreased urine output
- B. Decreased pulse rate
- C. Concentrated urine
- D. Decreased skin turgor

423. A patient is to be subjected for surgery but the patient's BMI is low. Where will you refer the patient?

- A. Speech and Language Therapist
- B. Dietician
- C. Chef
- D. Family member

424. A patient had been suffering from severe diarrhea and is now showing signs of dehydration. Which of the following is not a classic symptom?

- A. passing small amounts of urine frequently
- B. dizziness or light-headedness
- C. dark-coloured urine
- D. thirst

425. A relative of the patient was experiencing vomiting and diarrhoea and wished to visit her mother who was admitted. As a nurse, what will you advise to the patient's relative?

- a) There should be 48 hours after active symptoms should disappear prior to visiting patient
- b) Inform relative it is fine to visit mother as long as she uses alcohol before entering ward premises

426. Nurse caring a confused client not taking fluids, staff on previous shift tried to make him drink but were unsuccessful. Now it is the visitors time, wife is waiting outside What to do?

- a) Ask the wife to give him fluid, and enquire about his fluid preferences and

usual drinking time

- b) Tell her to wait and you need some time to make him drink
- c) Inform doctor to start iv fluids to prevent dehydration

427. **Causes of gingival bleeding**

- A. poor removal plaque
- B. poor flossing
- C. poor nutrition
- D. poor taking of drugs

428. **As a nurse you are responsible for looking after patient's nutritional needs and to maintain good weight during hospitalization. How would you achieve this?**

- a) Providing all clients with liquid nutritional supplements
- b) Assessing all patients using MUST screening tool and by taking patients preferences into consideration
- c) Checking daily weigh and documenting
- d) Assessing nutritional status, client preferences and needs, making individual food choices available, checking daily weight and documentation

429. **The client reports nausea and constipation. Which of the following would be the priority nursing action?**

- a. Collect a stool sample
- b. Complete an abdominal assessment
- c. Administer an anti-nausea medication
- d. Notify the physician

430. **A nurse is not allowing the client to go to bed without finishing her meal. What is your action as a RN?**

- a) Do nothing as client has to finish her meal which is important for her health
- b) Challenge the situation immediately as this is related to dignity of the patient and raise your concern
- c) Do nothing as patient is not under your care
- d) Wait until the situation is over and speak to the client on what she wants to do

431. **A nurse is preparing to deliver a food tray to a client whose religion is Jewish. The nurse checks the food on the tray and notes that the food on the tray and notes that the client has received a roast beef dinner with whole milk as a beverage. Which action will the nurse take?**

- A) Deliver the food tray to the client
- B) Call the dietary department and ask for a new meal tray
- C) Replace the whole milk with fat free milk
- D) Ask the dietary department to replace the roast beef with pork

432. **What is the use of protected meal time?**

- a) Patient get protection from visitors
- b) Staff get enough time to have their bank
- c) To give personal hygiene to patients who are confused
- d) Patients get enough time to eat food without distractions while staff focus on people who needs help with eating

**433. How many cups of fluid do we need every day to keep us well hydrated?**

- a) 1 to 2
- b) 2 to 4
- c) 4 to 6
- d) 6 to 8

**434. The human body is made up of approximately what proportion of water?**

- a) 50%
- b) 60%
- c) 70%
- d) 80%

**435. Concentration of electrolytes within the body vary depending on the compartment within which they are contained. Extracellular fluid has a high concentration of which of the following?**

- a) Potassium
- b) Chloride
- c) Sodium
- d) Magnesium

**436. Dehydration is of particular concern in ill health. If a patient is receiving IV fluid replacement and is having their fluid balance recorded, which of the following statements is true of someone said to be in "positive fluid balance"**

- a) The fluid input has exceeded the output
- b) The fluid balance chart can be stopped as "positive" means "good"
- c) The doctor may consider increasing the IV drip rate
- d) The fluid output has exceeded the input

**437. Mr. James, 72 years old, is a registered blind admitted on your ward due to dehydration. He is encouraged to drink and eat to recover. How will you best manage this plan of care?**

- a) Ask the patient the assistance he needs
- b) delegate someone to feed him
- c) ask the relatives to assist in feeding him

d) look for volunteer to assist with his needs

438. **What do you expect to manifest with fluid volume deficit?**

- a) Low pulse, Low Bp
- b) High pulse, High BP
- c) **High Pulse, low BP**
- d) Low Pulse, high BP

439. **Nurse caring a confused client not taking fluids, staff on previous shift tried to make him drink but were unsuccessful. Now it is the visitors time, wife is waiting outside What to do?**

- a) **Ask the wife to give him fluid, and enquire about his fluid preferences and usual drinking time**
- b) Tell her to wait and you need some time to make him drink
- c) Inform doctor to start iv fluids to prevent dehydration

440. **If your patient is having positive balance. How will you find out dehydration is balanced?**

- A. **Input exceeds output**
- B. Output exceeds input
- C. **Optimally hydrated**
- D. Optimally dehydrated

441. **A patient underwent an abdominal surgery and will be unable to meet nutritional needs through oral intake. A patient was placed on enteral feeding. How would you position the patient when feeding is being administered?**

- A. **Sitting upright at 30 to 45°**
- B. Sitting upright at 60 to 75°
- C. Sitting upright at 45 to 60
- D. Sitting upright at 75 to 90°

442. **What is positive fluid balance?**

- A. A deficit in fluid volume.
- B. **A state when fluid intake is greater than output.**
- C. Retention of both electrolytes and water in proportion to the levels in the extracellular fluid.
- D. A state where the body has less water than it needs to function properly.

443. **Perdue categorizes constipation as primary, secondary or iatrogenic. What could be some of the causes of iatrogenic constipation?**

- a) Inadequate diet and poor fluid intake
- b) Anal fissures, colonic tumours or hypercalcaemia.
- c) Lifestyle changes and ignoring the urge to defaecate.
- d) **Antiemetic or opioid medication**

444. **A patient is admitted to the ward with symptoms of acute diarrhoea. What should your initial management be?**

- a) Assessment, protective isolation, universal precautions.
- b) **Assessment, source isolation, antibiotic therapy.**
- c) Assessment, protective isolation, antimotility medication.
- d) **Assessment, source isolation, universal precautions**

445. **Concentration of electrolytes within the body vary depending on the compartment within which they are contained. Extracellular fluid has a high concentration of which of the following?**

- A. Potassium
- B. Chloride
- C. **Sodium**
- D. Magnesium

446. **Sign of dehydration**

- a) Bounding pulse
- b) Hypertension
- c) Jugular distension
- d) **Hypotension**

447. **What should be included in your initial assessment of your patients respiratory status?**

- A) Review the patients notes and charts, to obtain the patients history.
- B) Review the results of routine investigations.
- C) **Observe the patients breathing for ease and comfort, rate and pattern.**
- D) Perform a systematic examination and ask the relatives for the patient's history.

448. **When using nasal cannulae, the maximum oxygen flow rate that should be used is 6 litres/min. Why?**

- A) Nasal cannulae are only capable of delivering an inspired oxygen concentration between 24% and 40%.
- B) For any given flow rate, the inspired oxygen concentration will vary between breaths, as it depends upon the rate and depth of the patients breath and the inspiratory flow rate.

- C) Higher rates can cause nasal mucosal drying and may lead to epistaxis.
- D) If oxygen is administered at greater than 40% it should be humidified. You cannot humidify oxygen via nasal cannulae

449. **Why is it essential to humidify oxygen used during respiratory therapy?**

- A) Oxygen is a very hot gas so if humidification isn't used, the oxygen will burn the respiratory tract and cause considerable pain for the patient when they breathe.
- B) Oxygen is a dry gas which can cause evaporation of water from the respiratory tract and lead to thickened mucus in the airways, reduction of the movement of cilia and increased susceptibility to respiratory infection.
- C) Humidification cleans the oxygen as it is administered to ensure it is free from any aerobic pathogens before it is inhaled by the patient.

450. **What should be included in a prescription for oxygen therapy?**

- A) You don't need a prescription for oxygen unless in an emergency.
- B) The date it should commence, the doctor's signature and bleep number.
- C) The type of oxygen delivery system, inspired oxygen percentage and duration of the therapy.
- D) You only need a prescription if the patient is going to have home oxygen

451. **A COPD patient is in home care. When you visit the patient, he is dyspnoeic, anxious and frightened. He is already on 2 lit oxygen with nasal cannula. What will be your action**

- A. Call the emergency service.
- B. Give Oramorph 5mg medications as prescribed.
- C. Ask the patient to calm down.
- D. Increase the flow of oxygen to 5 L

452. **A COPD patient is about to be discharged from the hospital. What is the best health teaching to provide this patient?**

- A. Increase fluid intake
- B. Do not use home oxygen
- C. Quit smoking
- D. nebulize as needed

453. **Respiratory protective equipment include:**

- A. gloves
- B. mask
- C. apron
- D. paper towels

454. If a patient is prescribed nebulizers, what is the minimum flow rate in litres per minute required)

- a) 2-4
- b) 4-6
- c) 6-8
- d) 8-10

455. Which of the following is a potential complication of putting an oropharyngeal airway adjunct:

- A) Retching, vomiting
- B) Bradycardia
- C) Obstruction
- D) Nasal injury

456. Your patient has bronchitis and has difficulty in clearing his chest. What position would help to maximize the drainage of secretions?

- a) Lying flat on his back while using a nebulizer
- b) Sitting up leaning on pillows and inhaling humidified oxygen
- c) Lying on his side with the area to be drained uppermost after the patient has had humidified air
- d) Standing up in fresh air taking deep breaths

457. What do you need to consider when helping a patient with shortness of breath sit out in a chair?

- a) They should not sit out on a chair; lying flat is the only position for someone with shortness of breath so that there are no negative effects of gravity putting pressure in lungs
- b) Sitting in a reclining position with legs elevated to reduce the use of postural muscle oxygen requirements, increasing lung volumes and optimizing perfusion for the best V/Q ratio. The patient should also be kept in an environment that is quiet so they don't expend any unnecessary energy
- c) The patient needs to be able to sit in a forward leaning position supported by pillows. They may also need access to a nebulizer and humidified oxygen so they must be in a position where this is accessible without being a risk to others.
- d) There are two possible positions, either sitting upright or side lying. Which is used and is determined by the age of the patient. It is also important to remember that they will always need a nebulizer and oxygen and the air temperature must be below 20 degree Celsius

458. What should be included in your initial assessment of your patient's respiratory status?

- A) Review the patient's notes and charts, to obtain the patient's history.
- B) Review the results of routine investigations.
- C) Observe the patient's breathing for ease and comfort, rate and pattern.
- D) Perform a systematic examination and ask the relatives for the patient's history

459. Which is not considered in an oxygen prescription?

- A. It should be prescribed.
- B. Regular pulse oximetry monitoring must be available in all clinical environments.
- C. Can be given to patients who are not hypoxaemic.
- D. It must be signed and dated.

460. Patient is in for oxygen therapy

- A) A prescription is required including route, method and how long
- B) No prescription is required unless he will use it at home.
- C) Prescription not required for oxygen therapy

461. What should be included in your initial assessment of your patient's respiratory status?

- A. Review the patient's notes and charts, to obtain the patient's history.
- B. Review the results of routine investigations.
- C. Observe the patient's breathing for ease and comfort, rate and pattern.
- D. check for any drains
- E all of the above

462. You are caring for a 17 year old woman who has been admitted with acute exacerbation of asthma. Her peak flow readings are deteriorating and she is becoming wheezy. What would you do?

- A. Sit her upright, listen to her chest and refer to the chest physiotherapist.
- B. Suggest that the patient takes her Ventolin inhaler and continue to monitor the patient.
- C. Undertake a full set of observations to include oxygen saturations and respiratory rate. Administer humidified oxygen, bronchodilators, corticosteroids and antimicrobial therapy as prescribed.
- D. Reassure the patient: you know from reading her notes that stress and anxiety often trigger her asthma.

463. What do you expect patients with COPD to manifest?

- A) Inc Pco<sub>2</sub>, dec O<sub>2</sub>
- B) Dec Pco<sub>2</sub>, inc o<sub>2</sub>
- C) Inc pco<sub>2</sub>, inc o<sub>2</sub>
- D) Dec pco<sub>2</sub>, dec o<sub>2</sub>

**464. Which of the following indicates signs of severe Chronic Obstructive Pulmonary disease (COPD)?**

- A) high pO<sub>2</sub> and high pCO<sub>2</sub>
- B) Low pO<sub>2</sub> and low pCO<sub>2</sub>
- C) low pO<sub>2</sub> and high pCO<sub>2</sub>
- D) high pO<sub>2</sub> and low pCO<sub>2</sub>

**465. As a nurse, what health teachings will you give to a COPD patient?**

- A) Encourage to stop smoking
- B) Administer oxygen inhalation as prescribed
- C) Enroll in a pulmonary rehabilitation programme
- D) All the above

**466. You are caring for a patient with a history of COAD who is requiring 70% humidified oxygen via a facemask. You are monitoring his response to therapy by observing his colour, degree of respiratory distress and respiratory rate. The patient's oxygen saturations have been between 95% and 98%. In addition, the doctor has been taking arterial blood gases. What is the reason for this?**

- A. Oximeters may be unreliable under certain circumstances, e.g. if tissue perfusion is poor, if the environment is cold and if the patient's nails are covered with nail polish.
- B. Arterial blood gases should be sampled if the patient is receiving >60% oxygen.
- C. Pulse oximeters provide excellent evidence of oxygenation, but they do not measure the adequacy of ventilation.
- D. Arterial blood gases measure both oxygen and carbon dioxide levels and therefore give an indication of both ventilation and oxygenation

**467. What is the most accurate method of calculating a respiratory rate?**

- A) Counting the number of respiratory cycles in 15 seconds and multiplying by 4.
- B) Counting the number of respiratory cycles in 1 minute. One cycle is equal to the complete rise and fall of the patient's chest.
- C) Not telling the patient as this may make them conscious of their breathing pattern and influence the accuracy of the rate.
- D) Placing your hand on the patient's chest and counting the number of respiratory cycles in 30 seconds and multiplying by 2

**468. You are caring for a 17 year old woman who has been admitted with acute exacerbation of asthma. Her peak flow readings are deteriorating and she is becoming wheezy. What would you do?**

- A. Sit her upright, listen to her chest and refer to the chest physiotherapist.

- B. Suggest that the patient takes her Ventolin inhaler and continue to monitor the patient.
- C. Undertake a full set of observations to include oxygen saturations and respiratory rate. Administer humidified oxygen, bronchodilators, corticosteroids and antimicrobial therapy as prescribed
- D. Reassure the patient: you know from reading her notes that stress and anxiety often trigger her asthma

469. Which of the following is NOT a cause of Type 1 (hypoxaemic) respiratory failure?

- A) Asthma
- B) Pulmonary oedema
- C) Drug overdose
- D) Granulomatous lung disease

470. Prior to sending a patient home on oxygen, healthcare providers must ensure the patient and family understand the dangers of smoking in an oxygen-rich environment. Why is this necessary?

- a) It is especially dangerous to the patient's health to smoke while using oxygen
- b) Oxygen is highly flammable and there is a risk of fire
- c) Oxygen and cigarette smoke can combine to produce a poisonous mixture
- d) Oxygen can lead to an increased consumption of cigarette

471. What should be included in your initial assessment of your patient's respiratory status?

- A. Review the patient's notes and charts, to obtain the patient's history.
- B. Review the results of routine investigations.
- C. Observe the patient's breathing for ease and comfort, rate and pattern.
- D. Perform a systematic examination and ask the relatives for the patient's history

472. Prior to sending a patient home on oxygen, healthcare providers must ensure the patient and family understand the dangers of smoking in an oxygen-rich environment. Why is this necessary?

- A) It is especially dangerous to the patient's health to smoke while using oxygen
- B) Oxygen is highly flammable and there is a risk of fire
- C) Oxygen and cigarette smoke can combine to produce a poisonous mixture
- D) Oxygen can lead to an increased consumption of cigarette

473. You are caring for a patient with a history of COAD who is requiring 70% humidified oxygen via a facemask. You are monitoring his response to therapy by observing his colour, degree of respiratory distress and respiratory rate. The patient's oxygen saturations have been between 95% and 98%. In addition, the doctor has been taking arterial blood gases. What is the reason for this?

A) Oximeters may be unreliable under certain circumstances, e.g. if tissue perfusion is poor, if the environment is cold and if the patient's nails are covered with nail polish.

B) Arterial blood gases should be sampled if the patient is receiving >60% oxygen.

C) Pulse oximeters provide excellent evidence of oxygenation, but they do not measure the adequacy of ventilation.

D) Arterial blood gases measure both oxygen and carbon dioxide levels and therefore give an indication of both ventilation and oxygenation

474. A client breathes shallowly and looks upward when listening to the nurse. Which sensory mode should the nurse plan to use with this client?

- a) Touch
- b) Auditory
- c) Kinesthetic
- d) Visual

475. Is normal breathing, what is the main muscle(s) involved in inspiration?

- a) The diaphragm
- b) The lungs
- c) The intercostal
- d) All of the above

476. Joy, a COPD patient is to be discharged in the community. As her nurse, which of the following interventions will you encourage him to do to prevent progression of disease.

- A) Oxygen therapy
- B) Breathing exercise
- C) Cessation of smoking
- D) coughing exercise

477. While assisting a client from bed to chair, the nurse observes that the client looks pale and is beginning to perspire heavily. The nurse would then do which of the following activities as a reassessment?

- a) Help client into the chair but more quickly
- b) Document client's vital signs taken just prior to moving the client
- c) Help client back to bed immediately
- d) Observe client's skin color and take another set of vital signs

478. What percentage of the air we breathe is made up of oxygen?

- a) 16%
- b) 21%
- c) 26%
- d) 31%

479. Which of the following oxygen masks is able to deliver between 60-90% of oxygen when delivered at a flow rate of 10 – 15L/min?

- a) Simple semi rigid plastic masks
- b) Nasal cannulas
- c) Venture high flow mask
- d) Non-rebreathing masks

480. You are caring for a patient with a history of COAD who is requiring 70% humidified oxygen via a facemask. You are monitoring his response to therapy by observing his colour, degree of respiratory distress and respiratory rate. The patient's oxygen saturations have been between 95% and 98%. In addition, the doctor has been taking arterial blood gases. What is the reason for this?

A. Oximeters may be unreliable under certain circumstances, e.g. if tissue perfusion is

poor, if the environment

is cold and if the patient's nails are covered with nail polish.

B. Arterial blood gases should be sampled if the patient is receiving >60% oxygen.

C. Pulse oximeters provide excellent evidence of oxygenation, but they do not measure

the adequacy of ventilation.

D. Arterial blood gases measure both oxygen and carbon dioxide levels and therefore

give an indication of both ventilation and oxygenation.

481. A client diagnosed of cancer visits the OPD and after consulting the doctor breaks down in the corridor and begins to cry. What would the nurses best action?

- a) Ignore the client and let her cry in the hallway
- b) Inform the client about the preparing to come forth next appointment for further discussion on the treatment planned
- c) Take her to a room and try to understand her worries and do the needful and assist her with further information if required
- d) Explain her about the list of cancer treatments to survive

482. Your patient has bronchitis and has difficulty in clearing his chest. What position would help to maximize the drainage of secretions?

- a) Lying on his side with the area to be drained uppermost after the patient has had humidified air
- b) Lying flat on his back while using a nebulizer
- c) Sitting up leaning on pillows and inhaling humidified oxygen
- d) Standing up in fresh air taking deep breaths

483. **What is respiration?**

- A. the movement of air into and out of the lungs to continually refresh the gases there, commonly called 'breathing'
- B. movement of oxygen from the lungs into the blood, and carbon dioxide from the lungs into the blood, commonly called 'gaseous exchange'
- C. movement of oxygen from blood to the cells, and of carbon dioxide from the cells to the blood
- D. the transport of oxygen from the outside air to the cells within tissues, and the transport of carbon dioxide in the opposite direction.

484. **In normal breathing, what is the main muscle(s) involved in inspiration?**

- a) The diaphragm
- b) The lungs
- c) the intercostal
- d) All of the above

485. **Which of the following is NOT a cause of Type 1 (hypoxaemic) respiratory failure?**

- A. Asthma
- B. Pulmonary oedema
- C. Drug overdose
- D. Granulomatous lung disease

486. **If a patient is prescribed nebulizers, what is the minimum flow rate in litres per minute required?**

- a) 2 - 4
- b) 4 - 6
- c) 6 - 8
- d) 8 - 10

487. **When an oropharyngeal airway is inserted properly, what is the sign**

- a) Airway obstruction
- b) Retching and vomiting
- c) Bradycardia
- d) Tachycardia

488. **A patient under u developed shortness of breath while climbing stairs. U inform this to the doctor. This response is interpreted ass:**

- a) Breaching of patients confidentiality
- b) Essential, as it is the matter of patient's health

489. **You are caring for a 17 year old woman who has been admitted with acute exacerbation of asthma. Her peak flow readings are deteriorating and she is becoming wheezy. What would you do?**
- a) Sit her upright, listen to her chest and refer to the chest physiotherapist.
  - b) Suggest that the patient takes her Ventolin inhaler and continue to monitor the patient.
  - c) Undertake a full set of observations to include oxygen saturations and respiratory rate. Administer humidified oxygen, bronchodilators, corticosteroids and antimicrobial therapy as prescribed.
  - d) Reassure the patient: you know from reading her notes that stress and anxiety often trigger her asthma.
490. **Why is it essential to humidify oxygen used during respiratory therapy?**
- a) Oxygen is a very hot gas so if humidification isn't used, the oxygen will burn the respiratory tract and cause considerable pain for the patient when they breathe.
  - b) Oxygen is a dry gas which can cause evaporation of water from the respiratory tract and lead to thickened mucus in the airways, reduction of the movement of cilia and increased susceptibility to respiratory infection.
  - c) Humidification cleans the oxygen as it is administered to ensure it is free from any aerobic pathogens before it is inhaled by the patient.
491. **What should be included in your initial assessment of your patient's respiratory status?**
- a) Review the patient's notes and charts, to obtain the patient's history.
  - b) Review the results of routine investigations.
  - c) Observe the patient's breathing for ease and comfort, rate and pattern.
  - d) Perform a systematic examination and ask the relatives for the patient's history.
492. **Patient is in for oxygen therapy**
- a) A prescription is required including route, method and how long
  - b) No prescription is required unless he will use it at home.
  - c) Prescription not required for oxygen therapy
493. **Position to make breathing effective?**
- a) left lateral
  - b) Supine
  - c) Right Lateral
  - d) High sidelying

494. Reason for dyspnoea in patients who diagnosed with Glomerulonephritis patients?
- a) Albumin loss increase oncotic pressure causes water retention in cells
  - b) Albumin loss causes decrease in oncotic pressure causes water retention causing fluid retention I alveoli
  - c) Albumin loss has no effect on oncotic pressure
495. When an oropharyngeal airway is inserted properly, what is the sign
- a) Airway obstruction
  - b) Retching and vomiting
  - c) Bradycardia
  - d) Tachycardia
496. Lisa, a working mother of 3, has approached you during a recent attendance of her daughter in Accident and Emergency because of an acute asthma attack about smoking cessation. What is your most appropriate response to her?
- A. Smoking cessation will help prevent further asthma attack
  - B. Referral can be made to the local NHS Stop smoking service
  - C. Discuss with her the NICE recommendations on smoking cessation
  - D. It is not common for people like her to stop smoking
497. When do you gain consent from a patient and consider it valid?
- a) Only if a patient has the mental capacity to give consent
  - b) Only before a clinical procedure
  - c) None of the above
498. A patient is assessed as lacking capacity to give consent if they are unable to:
- A) Understand information about the decision and remember that information
  - B) Use that information to make a decision
  - C) Communicate their decision by talking, using sign language or by any other means
  - D) All the above
499. The following must be considered in procuring a consent, except:
- A. respect and support people's rights to accept or decline treatment or care
  - B. withhold people's rights to be fully involved in decisions about their care
  - C. be aware of the legislation regarding mental capacity
  - D. gain consent before treatment or care starts

**500. A patient has been assessed as lacking capacity to make their own decisions, what government legislation or act should be referred to:**

- a) Health and Social Care Act (2012)
- b) **Mental capacity Act (2005)**
- c) Carers (Equal opportunities) Act (2004)
- d) All of the above

**501. A patient puts out his arm so that you can take his blood pressure. What type of consent is this?**

- a) Verbal
- b) Written
- c) **Implied**
- d) None of the above, consent is not required.

**502. Who should mark the skin with an indelible pen ahead of surgery?**

- a) The nurse should mark the skin in consultation with the patient
- b) A senior nurse should be asked to mark the patient's skin
- c) **The surgeon should mark the skin**
- d) It is best not to mark the patient's skin for fear of distressing the patient.

**503. A patient is scheduled to undergo an Elective Surgery. What is the least thing that should be done?**

- A. Assess/Obtain the patient's understanding of, and consent to, the procedure, and a share in the decision making process.
- B. Ensure pre-operative fasting, the proposed pain relief method, and expected sequelae are carried out and discussed.
- C. **Discuss the risk of operation if it won't push through.**
- D. The documentation of details of any discussion in the anaesthetic record.

**504. What does assessing for no refusal means?**

- A) That the person has not already refused treatment
- B) That the person cannot or is unable to refuse treatment
- C) **That the person does not already have an advanced decision**
- D) **The person is already detained/ being treated under the mental health act.**

**505. Recommended preoperative fasting times are:**

- a) 2-4 hours
- b) **6-12 hours**
- c) 12-14 hours

**506. A patient is being prepared for a surgery and was placed on NPO. What is the purpose of NPO?**

- A. **Prevention of aspiration pneumonia**
- B. To facilitate induction of pre-op meds
- C. For abdominal procedures
- D. To decrease production of fluids

507. **Why is it important that patients are effectively fasted prior to surgery?**

- A) To reduce the risk of vomiting.
- B) To reduce the risk of reflux and inhalation of gastric contents.**
- C) To prevent vomiting and chest infections.
- D) To prevent the patient gagging

508. **It is important that patients are effectively fasted prior to surgery in order to:**

- a) reduce the risk of vomiting.
- b) reduce the risk of reflux and inhalation of gastric contents.**
- c) prevent vomiting and chest infections.
- d) prevent the patient gagging

509. **What are the principles of gaining informed consent prior to a planned surgery?**

- A) Gaining permission for an imminent procedure by providing information in medical terms, ensuring a patient knows the potential risks and intended benefits.
- B) Gaining permission from a patient who is competent to give it, by providing information, both verbally and with written material, relating to the planned procedure, for them to read on the day of planned surgery.
- C) Gaining permission from a patient who is competent to give it, by informing them about the procedure and highlighting risks if the procedure is not carried out.
- D) Gaining permission from a patient who is competent to give it, by providing information in understandable terms prior to surgery, allowing time for answering questions, and inviting voluntary participation.**

510. **What do you have to consider if you are obtaining a consent from the patient?**

- a) Understanding
- b) Capacity**
- c) Intellect
- d) Patient's condition

511. **Safe moving and handling of an anaesthetized patient is imperative to reduce harm to both the patient and staff. What is the minimum number of staff required to provide safe manual handling of a patient in theatre?**

- A) 3 (1 either side, 1 at head).
- B) 5 (2 each side, 1 at head).
- C) 4 (1 each side, 1 at head, 1 at feet).
- D) 6 (2 each side, 1 at head, 1 at feet).

512. How soon after surgery is the patient expected to pass urine?

- A) 1-2 hours
- B) 2-4 hours
- C) 4-6 hours
- D) 6-8 hours

513. What serious condition is a possibility for patients positioned in the Lloyd Davies position during surgery?

- A. Stroke
- B. Cardiac arrest
- C. Compartment syndrome
- D. There are no drawbacks to the Lloyd Davies position

514. As a registered nurse in a unit what would consider as a priority to a patient immediately post operatively?

- A) pain relief
- B) blood loss
- C) airway patency

515. patient just had just undergone lumbar laminectomy, what is the best nursing intervention?

- A) move the body as a unit
- B) move one body part at a time
- C) move the head first and the feet last
- D) never move the patient at all

516. A patient in your care is about to go for a liver biopsy. What are the most likely potential complications related to this procedure?

- A) Inadvertent puncture of the pleura, a blood vessel or bile duct
- B) Inadvertent puncture of the heart, oesophagus or spleen.
- C) Cardiac arrest requiring resuscitation.
- D) Inadvertent puncture of the kidney and cardiac arrest

517. Which of the following is a severe complication during 24 hrs post liver biopsy?

- A) pain at insertion site
- B) nausea and vomiting

- C) back pain
- D) bleeding

518. Patient is post op liver biopsy which is a sign of serious complication?  
(Select x 2 correct answers)

- A) CR of 104, RR=24, Temp of 37.5
- B) Nausea and vomiting
- C) Pain
- D) Bleeding

519. A nurse assists the physician in performing liver biopsy. After the biopsy the nurse places the patient in which position?

- a) Supine
- b) Prone
- c) Left-side lying
- d) Right side lying

520. A patient in your care is about to go for a liver biopsy. What are the most likely potential complications related to this procedure?

- A. Inadvertent puncture of the pleura, a blood vessel or bile duct
- B. Inadvertent puncture of the heart, oesophagus or spleen.
- C. Cardiac arrest requiring resuscitation.
- D. Inadvertent puncture of the kidney and cardiac arrest

521. What position should you prepare the patient in pre-op for abdominal Paracentesis?

- A) Supine
- B) Supine with head of bed elevated to 40-50cm
- C) Prone
- D) Side-lying

522. Lumbar post op patient moving and handling

- A) Move patient as a unit
- B) Move patient close to side rails so he/she could assist herself
- C) Move with leg raised/flexed

523. Patient is post of repair of tibia and fibula possible signs of compartment syndrome include

- A) Numbness and tingling
- B) Cool dusky toes
- C) Pain

- D) Toes swelling
- E) All of the above

524. Which of the following methods of wound closure is most suitable for a good cosmetic result following surgery?

- A) Skin clips
- B) Tissue adhesive
- C) Adhesive skin closure strips
- D) Interrupted suture

525. You are looking after a postoperative patient and when carrying out their observations, you discover that they are tachycardic and anxious, with an increased respiratory rate. What could be happening? What would you do?

- A) The patient is showing symptoms of hypovolaemic shock. Investigate source of fluid loss, administer fluid replacement and get medical support.
- B) The patient is demonstrating symptoms of atelectasis. Administer a nebulizer, refer to physiotherapist for assessment.
- C) The patient is demonstrating symptoms of uncontrolled pain. Administer prescribed analgesia, seek assistance from medical team.
- D) The patient is demonstrating symptoms of hyperventilation. Offer reassurance, administer oxygen

526. Who should mark the skin with an indelible pen ahead of surgery?

- A) The nurse should mark the skin in consultation with the patient
- B) A senior nurse should be asked to mark the patient's skin
- C) The surgeon should mark the skin
- D) It is best not to mark the patient's skin for fear of distressing the patient.

527. What serious condition is a possibility for patients positioned in the Lloyd Davies position during surgery?

- A) Stroke
- B) Cardiac arrest
- C) Compartment syndrome
- D) There are no drawbacks to the Lloyd Davies position

528. In which of the following situations might nitrous oxide (Entonox) be considered?

- a) A wound dressing change for short term pain relief or the removal of a chest drain for reduction of anxiety.

- b) Turning a patient who has bowel obstruction because there is an expectation that they may have pain from pathological fractures
- c) For pain relief during the insertion of a chest drain for the treatment of a pneumothorax.
- d) For pain relief during a wound dressing for a patient who has had radical head and neck cancer that involved the jaw.

**529. An adult has been medicated for her surgery. The operating room (OR) nurse, when going through the client's chart, realizes that the consent form has not been signed. Which of the following is the best action for the nurse to take?**

- a) Assume it is emergency surgery & the consent is implied
- b) Get the consent form & have the client sign it
- c) Tell the physician that the consent form is not signed
- d) Have a family member sign the consent form

**530. A patient has just returned from theatre following surgery on their left arm. They have a PCA infusion connected and from the admission, you remember that they have poor dexterity with their right hand. They are currently pain free. What actions would you take?**

- A) Educate the patient's family to push the button when the patient asks for it. Encourage them to tell the nursing staff when they leave the ward so that staff can take over.
- B) Routinely offer the patient a bolus and document this clearly.
- C) Contact the pain team/anaesthetist to discuss the situation and suggest that the means of delivery are changed.
- D) The patient has paracetamol q.d.s. written up, so this should be adequate pain relief

**531. The night after an exploratory laparotomy, a patient who has a nasogastric tube attached to low suction reports nausea. A nurse should take which of the following actions first?**

- A) Administer the prescribed antiemetic to the patient.
- B) Determine the patency of the patient's nasogastric tube.
- C) Instruct the patient to take deep breaths.
- D) Assess the patient for pain

**532. An adult is offered the opportunity to participate in research on a new therapy. The researcher ask the nurse to obtain the patient's consent. What is most appropriate for the nurse to take?**

- a) Be sure the patient understands the project before signing the consent form
- b) Read the consent form to the patient & give him or her an opportunity to

ask questions

c) **Refuse to be the one to obtain the patient's consent**

d) Give the form to the patient & tell him or her to read it carefully before signing it.

**533. Now the medical team encourages early ambulation in the post-operative period. which complication is least prevented by this?**

A) Tissue wasting

**B) Thrombophlebitis**

**C) Wound infection**

D) Pneumonia

**534. A patient doesn't sign the consent for mastectomy. But bystanders strongly feel that she needs surgery.**

A) Allow family members to take decision on behalf of patient

B) Doc can proceed with surgery, since it is in line with the best interest and outcome

**C) Respect patients decision. She has the right to accept or deny**

**535. You are the nurse assigned in recovery room or post anaesthetic care unit. The main priority of care in such area is:**

**a) Keeping airway intact**

b) keeping patient pain free

c) keeping neurological condition stable

d) keeping relatives informed of patient's condition

**536. Accurate postoperative observations are key to assessing a patient's deterioration or recovery. The Modified Early Warning Score (MEWS) is a scoring system that supports that aim. What is the primary purpose of MEWS?**

**a) Identifies patients at risk of deterioration.**

**b) Identifies potential respiratory distress.**

c) improves communication between nursing staff and doctors.

d) Assesses the impact of pre-existing conditions on postoperative recovery

**537. if a client is experiencing hypotension post operatively, the head is not tilted in which of the following surgeries**

**a) Chest surgery**

b) Abdominal surgery

**c) Gynaecological surgery**

d) Lower limb surgery

538. **Gurgling sound from airway in a postoperative client indicates what**

- a) Complete obstruction of lower airway
- b) **Partial obstruction of upper airway**
- c) Common sign of a post-operative patient
- d) Indicates immediate insertion of laryngeal airway

539. **What is the preferred position for abdominal Paracentesis?**

- a) **Supine with head slightly elevated**
- b) Supine with knees bent
- c) Prone
- d) Side-lying

540. **Famous actress has had plastic surgery. The media contacts the nurse on the unit and asks for information about the surgery. The nurse knows:**

- a) Any information released will bring publicity to the hospital
- b) **Nurse are obligated to respect client's privacy and confidentiality**
- c) It does not matter what is disclosed, the media will find out any way
- d) According the beneficence, the nurse has an obligation to implement actions that will benefit clients.

541. **What is right in case of consent among children under 18.**

- a) Only children between 16-18 are competent to give it.
- b) Parents are responsible to give consent with children
- c) **Children who are intellectually developed and understand matters can give consent**

542. **Early ambulation prevents all complications except:**

- a) Chest infection and lung collapse
- b) Muscle wasting
- c) Thrombosis
- d) **Surgical site infection**

543. **A patient has just returned from theatre following surgery on his left arm. He has a PCA infusion connected and from the admission, you remember that they have poor dexterity with his right hand. He is currently pain free. What actions would you take?**

- A. Educate the patient's family to push the button when the patient asks for it. Encourage them to tell the nursing staff when they leave the ward so that staff can take over.
- B. Routinely offer the patient a bolus and document this clearly.

C. **Contact the pain team/anaesthetist to discuss the situation and suggest that the means of delivery are changed.**

E. The patient has paracetamol q.d.s. written up, so this should be adequate pain relief.

544. **A patient with learning disability is accompanied by a voluntary independent mental capacity advocate. What is his role?**

- a) Express patients' needs and wishes. Acts as a patient's representative in expressing their concerns as if they were his own
- b) Just to accompany the patient
- c) To take decisions on patient's behalf and provide their own judgements as this benefit the client
- d) **Is expert and representative's clients concerns, wishes and views as they cannot express by themselves**

545. **Barbara, a 75-year old patient from a nursing home was admitted on your ward because of fractured neck of femur after a trip. She will require an open-reduction and internal fixation (ORIF) procedure to correct the injury. Which of the following statements will help her understand the procedure?**

- a) You are going to have an ORIF done to correct your fracture.
- b) **Some metal screws and pins will be attached to your hip to help with the healing of your broken bone.**
- c) The operation will require a metal fixator implanted to your femur and adjacent bones to keep it secured
- d) The ORIF procedure will be done under general anaesthesia by an orthopaedic surgeon

546. **You went back to see Mr Derby who is 1 day post-herniorrhaphy. As you approach him he complained of difficulty of breathing with respiration rate of 23 breaths per minute and oxygen saturation 92% in room air. What is your next action to help him?**

- a) **give him oxygen**
- b) **give him pain relief**
- c) give him antibiotics
- d) give him nebulisers

547. **Barbara was screaming in pain later in the day despite the PCA in-situ. You refer back to your nurse in charge for a stronger pain killer. She refused to call the doctor because her pain relief was reassessed earlier. What will you **do next?****

- A. **Continue to refer back to her until she calls the doctor**
- B. **Encourage Barbara to continuously use the PCA**
- C. Give Barbara some sedatives to keep her calm
- D. Wait until her pain stops

548. **Covert communication may include the following except:**

- A) Body language
- B) **tone of voice**
- C) appearance
- D) eye contact

549. **Which of the following statements by a nurse would indicate an understanding of intrapersonal communications?**

- a) **Intrapersonal communications occurs within a person**
- b) Intrapersonal communications occurs within a person
- c) Intrapersonal communications occur between two or more people
- d) Interpersonal communications is the same as intrapersonal communication"
- e) Nurses should avoid using intrapersonal communications

550. **A nurse has been told that a client's communications are tangential. The nurse would expect that the clients verbal responses to questions would be:**

- A. Long and wordy
- B. **Loosely related to the questions**
- C. Rational and logical
- D. Simplistic, short and incomplete

551. **An example of a positive outcome of a nurse-health team relationship would be:**

- A. **Receiving encouragement and support from co-workers to cope with the many stressors of the nursing role**
- B. Becoming an effective change agent in the community
- C. An increased understanding of the family dynamics that affect the client
- D. An increased understanding of what the client perceives as meaningful from his or her perspective

552. **Which therapeutic communication technique is being used in this nurse-client interaction?**

- a) Formulating a plan of action
- b) **Making observations**
- c) Exploring
- d) Encouraging comparison

553. **Which nursing statement is a good example of the therapeutic communication technique of giving recognition?**

- a) **I notice you are wearing a new dress and you have washed your hair"**
- b) You did not attend group today. Can we talk about that?
- c) I'll sit with you until it is time for your family session

d) I'm happy that you are now taking your medications. They will really help

554. The nursing staff communicates that the new manager has a focus on the "bottom line," and little concern for the quality of care. What is likely true of this nurse manager?

- A. The manager is looking at the total care picture.
- B. The manager is communicating the importance of a caring environment.
- C. The manager understands the organization's values and how they mesh with the manager's values.
- D. The manager is unwilling to listen to staff concerns unless they have an impact on costs.

555. Which nursing statement is good example of the therapeutic communication technique of focusing?

- a) Your counselling session is in 30 minutes. I'll stay with you until then."
- b) You mentioned your relationship with your father. Let's discuss that further
- c) I'm having a difficult time understanding what you mean
- d) Describe one of the best things that happened to you this week

556. The nurse asks a newly admitted client. "What can we do to help you?" What is the purpose of this therapeutic communication technique?

- a) To explore a subject, idea, experience, or relationship
- b) To communicate that the nurse is listening to the conversation
- c) To reframe the client's thoughts about mental health treatment
- d) To put the client at ease

557. Which therapeutic communication technique should the nurse use when communicating with a client who is experiencing auditory hallucinations?

- a) I wouldn't worry about these voices,. The medication will make them disappear
- b) Why not turn up the radio so that the voices are muted
- c) My sister has the same diagnosis as you and she also hears voices
- d) I understand that the voices seem real to you, but i do not hear any voices

558. Which therapeutic statement is a good example of the therapeutic communication technique of offering self?

- a) Would you like me to accompany you to your electroconvulsive therapy treatment?"
- b) I think it would be great if you talked about that problem during our next group session."
- c) After discharge, would you like to meet me for lunch to review your outpatient progress?"

- d) I notice that you are offering help to other peers in the milieu."

**559. Which nursing response is an example of the nontherapeutic communication block of requesting an explanation?**

- a) keep your chin up. I'll explain the procedure to you
- b) There is always an explanation for both good and bad behaviours
- c) Can you tell me why you said that?
- d) Are you not understanding the explanation I provided

**560. Which behaviours will encourage a patient to talk about their concerns?**

- a) Giving reassurance and telling them not to worry.
- b) Asking the patient about their family and friends.
- c) Tell the patient you are interested in what is concerning them and that you are available to listen.
- d) Tell the patient you are interested in what is concerning them and if they tell you, they will feel better.

**561. Which of the following descriptors is most appropriate to use when stating the "problem" part of a nursing diagnosis?**

- a) Grimacing
- b) Anxiety
- c) Oxygenation saturation 93%
- d) Output 500 mL in 8 hours

**562. Which of the following statements by a nurse would indicate an understanding of intrapersonal communications?**

- a) "Intrapersonal communications occur between two or more people."
- b) "Intrapersonal communications occurs within a person"
- c) "Interpersonal communications is the same as intrapersonal communications."
- d) "Nurses should avoid using intrapersonal communications."

**563. Which nursing response is an example of the nontherapeutic communication block of requesting an explanation?**

- A. "Can you tell me why you said that?"
- B. "Keep your chin up. I'll explain the procedure to you."
- C. "There is always an explanation for both good and bad behaviours."
- D. "Are you not understanding the explanation I provided?"

**564. What are the principles of communicating with a patient with delirium?**

- a) Use short statements & closed questions in a well –lit, quiet , familiar environment
- b) Use short statements & open questions in a well lit, quiet, familiar environment

- c) Write down all questions for the patient to refer back to
- d) Communicate only through the family using short statements & closed questions

**565. Which nursing response is an example of the nontherapeutic communication block of requesting an explanation?**

- A. "Can you tell me why you said that?"
- B. "Keep your chin up. I'll explain the procedure to you."
- C. "There is always an explanation for both good and bad behaviors."
- D. "Are you not understanding the explanation I provided?"

**566. Patient has just been told by the physician that she has stage III uterine cancer. The patient says to the nurse, "I don't know what to do. How do I tell my husband?" and begins to cry. Which of the following responses by the nurse is the MOST therapeutic?**

- A. "It seems to be that this is a lot to handle. I'll stay here with you."
- B. "How do you think would be best to tell your husband?"
- C. "I think this will all be easier to deal with than you think."
- D. "Why do you think this is happening to you?"

**567. Which therapeutic communication technique should the nurse use when communicating with a client who is experiencing auditory hallucinations?**

- A. "My sister has the same diagnosis as you and she also hears voices."
- B. "I understand that the voices seem real to you, but I do not hear any voices."
- C. "Why not turn up the radio so that the voices are muted."
- D. "I wouldn't worry about these voices. The medication will make them disappear."

**568. When communicating with someone who isn't a native English speaker, which of the following is NOT advisable?**

- a) Using a translator
- b) Use short, precise sentences
- c) Relying on their family or friends to help explain what you mean
- d) Write things down

**569. Which nursing statement is a good example of the therapeutic communication technique of offering self?**

- A. "I think it would be great if you talked about that problem during our next group session."
- B. "Would you like me to accompany you to your electroconvulsive therapy

treatment?"

C. "I notice that you are offering help to other peers in the milieu."

D. "After discharge, would you like to meet me for lunch to review your outpatient progress?"

**570. Mr Khan, is visiting his son in London when he was admitted in accident and emergency due to abdominal pain. Mr. Khan is from Pakistan and does not speak the English language. As his nurse, what is your best action:**

a) Ask the relative

b) Ask a cleaner who speaks the same

c) Ask for an official interpreter

d) Transfer him to another hospital who can communicate with him

**571. When communicating with someone who isn't a native English speaker, which of the following is advisable?**

a) Using an official translator

b) Ask the doctor

c) Relying on their family or friends

d) Ask the receptionist

**572. When communicating with a client who speaks a different language, which best practice should the nurse implement?**

a) Speak loudly & slowly

b) Arrange for an interpreter to translate

c) Speak to the client & family together

d) Stand close to the client & speak loudly

**573. What factors are essential in demonstrating supportive communication to patients?**

a) Listening, clarifying the concerns and feelings of the patient using open questions.

b) Listening, clarifying the physical needs of the patient using closed questions

c) Listening, clarifying the physical needs of the patient using open questions

d) Listening, reflecting back the patient's concerns and providing a solution.

**574. Which nursing statement is a good example of the therapeutic communication technique of giving recognition?**

A. "You did not attend group today. Can we talk about that?"

B. "I'll sit with you until it is time for your family session."

- C. "I notice you are wearing a new dress and you have washed your hair."  
D. "I'm happy that you are now taking your medications. They will really help."

575. When a patient arrives to the hospital who speaks a different language. Who is responsible for arranging an interpreter?

- a) Doctor
- b) Management
- c) Registered Nurse

576. Communication is not the message that was intended but rather the message that was received. The statement that best helps explain this is

- a) Clean communication can ensure the client will receive the message intended
- b) Sincerity in communication is the responsibility of the sender and the receiver
- c) Attention to personal space can minimize misinterpretation of communication
- d) Contextual factors, such as attitudes, values, beliefs, and self-concept, influence communication

577. Which of the following is NOT an example of non-verbal communication?

- a) Dress
- b) Facial expression
- c) Posture
- d) Tone

578. When communicating with someone who isn't a native English speaker, which of the following is NOT advisable?

- a) Using a translator
- b) Use short, precise sentences
- c) Relying on their family or friends to help explain what you mean
- d) Write things down

579. Which of these is an example of an open question?

- a) Are you feeling better today?
- b) When you said you are hurt, what do you mean?
- c) Can you tell me what is concerning you?
- d) Is that what you are looking for?

580. According to Argyle (1988), when two people communicate what percentage of what is communicated is actually in the words spoken?

- a) 90%

- b) 50%
- c) 23%
- d) 7%

581. Which of the following are barriers to effective communication?

- a) Cultural differences
- b) Unfamiliar accents
- c) Overly technical language and terminology
- d) Hearing problems

582. A nurse has been told that a client's communications are tangential. The nurse would expect that the client's verbal responses to questions would be:

- a) Long and wordy
- b) Loosely related to the questions
- c) Rational and logical
- d) Simplistic, short and incomplete

583. Which of the following is NOT an example of non-verbal communication?

- a) Dress
- b) Facial expression
- c) Posture
- d) Tone

584. Which of the following approaches creates a barrier to communication?

- a) Using too many different skills during a single interaction
- b) Giving advice rather than encouraging the patient to problem solve
- c) Allowing the patient to become too anxious before changing the subject
- d) Focusing on what the patient is saying rather than on the skill used

585. Which behaviours will encourage a patient to talk about their concerns?

- a) Giving reassurance and telling them not to worry.
- b) Asking the patient about their family and friends.
- c) Tell the patient you are interested in what is concerning them and that you are available to listen.
- d) Tell the patient you are interested in what is concerning them and if they tell you, they will feel better.

586. What law should be taken into consideration when a patient has hearing difficulties and would need hearing aids?

- a) Mental capacity Act
- b) Equality act**
- c) Communication law

**587. In non-verbal communication, what does SOLER stand for?**

- a) Squarely, open posture, leaning slightly forward, eye contact, relaxed**
- b) Squarely, open ended questions, leaning slightly forward, eye contact, relaxed
- c) Squarely, open posture, leaning forward, eye contact, rested
- d) Squarely, open ended questions, leaning slightly backwards, rested

**588. The CQC describes compassion as what?**

- A) Intelligent Kindness**
- B) Smart confidence
- C) Creative commitment
- D) Gifted courage

**589. A patient who doesn't know English comes to hospital. Ur role?**

- A) Use a professional interpreter**
- B) Try to use nonverbal communication techs
- C) Use the security who knows patient's language

**590. Which behaviors will encourage a patient to talk about their concerns?**

- A. Giving reassurance & telling them not to worry
- B. Asking the patient about their family & friends
- C. Tell the patient you are interested in what is concerning them & that you are available to listen
- D. Tell the patient you are interested in what is concerning them if they tell you, they will feel better**

**591. What is the difference between denial & collusion?**

- A. Denial is when a healthcare professional refuses to tell a patient their diagnosis for the protection of the patient whereas collusion is when healthcare professionals & the patient agree on the information to be told to relatives & friends
- B. Denial is when a patient refuses treatment & collusion is when a patient agrees to it
- C. Denial is a coping mechanism used by an individual with the intention of protecting themselves from painful or distressing information whereas collusion is the withholding of information from the patient with the intention of 'protecting them'**

D. Denial is a normal acceptable response by a patient to a life-threatening diagnosis whereas collusion is not

592. Which nursing statement is a good example of the therapeutic communication technique of giving recognition?

- A. "You did not attend group today. Can we talk about that?"
- B. "I'll sit with you until it is time for your family session."
- C. "I notice you are wearing a new dress and you have washed your hair."
- D. "I'm happy that you are now taking your medications. They will really help."

593. If you were explaining anxiety to a patient, what would be the main points to include?

A. Signs of anxiety include behaviours such as muscle tension, palpitations, a dry mouth, fast shallow breathing, dizziness & an increased need to urinate or defaecate

B. Anxiety has three aspects: physical – bodily sensations related to flight & fight response, behavioural – such as avoiding the situation, & cognitive (thinking) – such as imagining the worst

C. Anxiety is all in the mind, if they learn to think differently, it will go away

D. Anxiety has three aspects: physical – such as running away, behavioural – such as imagining the worse (catastrophizing), & cognitive (thinking) – such as needing to urinate.

594. What are the principles of communicating with a patient with delirium?

A. Use short statements & closed questions in a well-lit, quiet, familiar environment

B. Use short statements & open questions in a well lit, quiet, familiar environment

C. Write down all questions for the patient to refer back to

D. Communicate only through the family using short statements & closed questions

595. Which of the following statements by a nurse would indicate an understanding of intrapersonal communications?

A. "Intrapersonal communications occur between two or more people."

B. "Intrapersonal communications occurs within a person"

C. "Interpersonal communications is the same as intrapersonal communications."

D. "Nurses should avoid using intrapersonal communications."

596. The nurse asks a newly admitted client, "What can we do to help you?" What is the purpose of this therapeutic communication technique?

A. To reframe the client's thoughts about mental health treatment

- B. To put the client at ease
- C. To explore a subject, idea, experience, or relationship
- D. To communicate that the nurse is listening to the conversation

597. Covert communication may include the following except:

- A. Body language
- B. tone of voice
- C. appearance
- D. eye contact

598. Which therapeutic communication technique is being used in this nurse-client interaction?

Client: "When I get angry, I get into a fistfight with my wife or I take it out on the kids."

Nurse: "I notice that you are smiling as you talk about this physical violence."

- A. Encouraging comparison
- B. Exploring
- C. Formulating a plan of action
- D. Making observations

599. The nurse asks a newly admitted client, "What can we do to help you?" What is the purpose of this therapeutic communication technique?

- a) To reframe the client's thoughts about mental health treatment
- b) To put the client at ease
- c) To explore a subject, idea, experience, or relationship
- d) To communicate that the nurse is listening to the conversation

600. Which nursing statement is a good example of the therapeutic communication technique of focusing?

- A. "Describe one of the best things that happened to you this week."
- B. "I'm having a difficult time understanding what you mean."
- C. "Your counseling session is in 30 minutes. I'll stay with you until then."
- D. "You mentioned your relationship with your father. Let's discuss that further."

601. Which nursing statement is a good example of the therapeutic communication technique of offering self?

- A. "I think it would be great if you talked about that problem during our next group session."
- B. "Would you like me to accompany you to your electroconvulsive therapy treatment?"

C. "I notice that you are offering help to other peers in the milieu."

D. "After discharge, would you like to meet me for lunch to review your outpatient progress?"

**602. On a psychiatric unit, the preferred milieu environment is BEST described as:**

A. Providing an environment that is safe for the patient to express feelings.

B. Fostering a sense of well-being and independence in the patient.

C. Providing an environment that will support the patient in his or her therapeutic needs.

D. Fostering a therapeutic social, cultural, and physical environment.

**603. A new mother is admitted to the acute psychiatric unit with severe postpartum depression. She is tearful and states, "I don't know why this happened to me! I was so excited for my baby to come, but now I don't know!" Which of the following responses by the nurse is MOST therapeutic?**

A. "Having a new baby is stressful, and the tiredness and different hormone levels don't help. It happens to many new mothers and is very treatable."

B. "Maybe you weren't ready for a child after all."

C. "What happened once you brought the baby home? Did you feel nervous?"

D. "Has your husband been helping you with the housework at all?"

**604. A patient with antisocial personality disorder enters the private meeting room of a nursing unit as a nurse is meeting with a different patient. Which of the following statements by the nurse is BEST?**

A. "I'm sorry, but HIPPA says that you can't be here. Do you mind leaving?"

B. "You may sit with us as long as you are quiet."

C. "I need you to leave us alone."

D. "Please leave and I will speak with you when I am done."

**605. The wife of a client with PTSD (post traumatic stress disorder) communicates to the nurse that she is having trouble dealing with her husband's condition at home. Which of the following suggestions made by the nurse is CORRECT?**

A. "Discourage your husband from exercising, as this will worsen his condition."

B. "Encourage your husband to avoid regular contact with outside family members."

C. "Do not touch or speak to your husband during an active flashback. Wait until it is finished to give him support."

D. "Keep your cupboards free of high-sugar and high-fat foods."

**606. A client expressed concern regarding the confidentiality of her medical information. The nurse assures the client that the nurse maintains client confidentiality by:**

- A. Sharing the information with all members of the health care team.
- B. Limiting discussion about clients to the group room and hallways.
- C. Summarizing the information the client provides during assessments and documenting this summary in the chart.
- D. Explaining the exact limits of confidentiality in the exchanges between the client and the nurse.**

**607. When caring for clients with psychiatric diagnoses, the nurse recalls that the purpose of psychiatric diagnoses or psychiatric labeling is to:**

- A. Identify those individuals in need of more specialized care.
- B. Identify those individuals who are at risk for harming others.
- C. Enable the client's treatment team to plan appropriate and comprehensive care.**
- D. Define the nursing care for individuals with similar diagnoses.

**608. A client breathes shallowly and looks upward when listening to the nurse. Which sensory mode should the nurse plan to use with this client?**

- a) Auditory
- b) Kinesthetic
- c) Touch**
- d) Visual**

**609. Which is the most appropriate phrase to communicate?**

- a) I'm sorry, your mother died.**
- b) I'm sorry, your mother gone to heaven
- c) I'm sorry, your mother is no longer with us.
- d) I'm sorry, your mother passed away.

**610. What factors are essential in demonstrating supportive communication to patients?**

- a) Listening, clarifying the concerns and feelings of the patient using open questions.**
- b) Listening, clarifying the physical needs of the patient using closed questions.
- c) Listening, clarifying the physical needs of the patient using open questions.
- d) Listening, reflecting back the patient's concerns and providing a solution.

**611. What is supportive communication?**

- a) To listen and clarify using close-ended questions
- b) A communication that seeks to preserve a positive relationship between the communicators while still addressing the problem at hand
- c) It involves a self-perceived flaw that an individual refuse to admit to another person, a sensitivity to that flaw, and an attack by another person that focuses on the flaw
- d) The face to face process of interacting that focuses on advancing the physical and emotional wellbeing of a patient.

612. Which therapeutic communication technique should the nurse use when communicating with a client who is experiencing auditory hallucinations?

- A. "My sister has the same diagnosis as you and she also hears voices."
- B. "I understand that the voices seem real to you, but I do not hear any voices."
- C. "Why not turn up the radio so that the voices are muted."
- D. "I wouldn't worry about these voices. The medication will make them disappear."

613. Which behaviors will encourage a patient to talk about their concerns?

- a) Giving reassurance & telling them not to worry
- b) Asking the patient about their family & friends
- c) Tell the patient you are interested in what is concerning them & that you are available to listen
- d) Tell the patient you are interested in what is concerning them if they tell you , they will feel better

614. Which therapeutic communication technique is being used in this nurse-client interaction?

Client: "When I get angry, I get into a fistfight with my wife or I take it out on the kids."

Nurse: "I notice that you are smiling as you talk about this physical violence."

- a) Encouraging comparison
- b) Exploring
- c) Formulating a plan of action
- d) Making observations

615. During which part of the client interview would it be best for the nurse to ask, "What's the weather forecast for today?"

- A. Introduction
- B. Body
- C. Closing
- D. Orientation

616. The nurse is leading an in service about management issues. The nurse would intervene if another nurse made which of the following statements?

- a) "It is my responsibility to ensure that the consent form has been signed and attached to the patient's chart prior to surgery."
- b) "It is my responsibility to witness the signature of the client before surgery is performed."
- c) "It is my responsibility to answer questions that the patient may have prior to surgery."
- d) "It is my responsibility to provide detailed description of the surgery and ask the patient to sign the consent form."

617. Compassion is best described as:

- a) showing empathy when delivering care
- b) not answering relatives queries
- c) giving patient some monies to buy unhealthy food
- d) providing care without gaining consent

618. Compassion in Practice – the culture of compassionate care encompasses:

- a) Care, Compassion, Competence, Communication, Courage, Commitment - DoH – "Compassion in Practice"
- b) Care, Compassion, Competence
- c) Competence, Communication, Courage
- d) Care, Courage, Commitment

619. when breaking bad news over phone which of the following statement is appropriate

- a) I am sorry to tell you that your mother died
- b) I am sorry to tell you that your mother has gone to heaven
- c) I am sorry to tell you that your mother is no more
- d) I am sorry to tell you that your mother passed away

620. The nurse should avoid asking the client which of the following leading questions during a client interview.

- A. "What medication do you take at home?"
- B. "You are really excited about the plastic surgery, aren't you?"
- C. "Were you aware I've has this same type of surgery?"
- D. "What would you like to talk about?"

621. The nurse is most likely to collect timely, specific information by asking which of the following questions?

- A. "Would you describe what you are feeling?"
- B. "How are you today?"
- C. "What would you like to talk about?"
- D. "Where does it hurt?"

622. A client comes to the local clinic complaining that sometimes his heart pounds and he has trouble sleeping. The physical exam is normal. The nurse learns that the client has recently started a new job with expanded responsibilities and is worried about succeeding. Which of the following responses by the nurse is BEST?

- A) Have you talked to your family about your concerns?
- B) You appear to have concerns about your ability to do your job
- C) You could benefit from counselling
- D) It's normal to feel anxious when starting a new job

623. An example of a positive outcome of a nurse-health team relationship would be:

- a) Receiving encouragement and support from co-workers to cope with the many stressors of the nursing role
- b) Becoming an effective change agent in the community
- c) An increased understanding of the family dynamics that affect the client
- d) An increased understanding of what the client perceives as meaningful from his or her perspective

624. Mrs X is posted for CT scan. Patient is afraid cancer will reveal during her scan. She asks "why is this test". What will be your response as a nurse?

- A. Understand her feelings and tell the patient that it is a normal procedure.
- B. Tell her that you will arrange a meeting with doctor after the procedure.
- C. Give a health education on cancer prevention
- D. Ignore her question and take her for the procedure.

625. Which of these is not a symptom of an ectopic pregnancy?

- A. Pain
- B. Bleeding
- C. Vomiting
- D. Diarrhoea



626. A young woman gets admitted with abdominal pain & vaginal bleeding. Nurse should consider an ectopic pregnancy. Which among the following is not a symptom of ectopic pregnancy?

- a) Pain at the shoulder tip
- b) **Dysuria**
- c) Positive pregnancy test

627. **The signs and symptoms of ectopic pregnancy except:**

- a) Vaginal bleeding
- b) Positive pregnancy test
- c) Shoulder tip pain
- d) **Protein excretion exceeds 2 g/day**

628. **Which of the following is NOT a risk factor for ectopic pregnancy**

- a) **Alcohol abuse**
- b) Smoking
- c) Tubal or pelvic surgery
- d) previous ectopic pregnancy

629. **What is not a sign of meconium aspiration**

- a) Floppy in appearance
- b) Apnoea
- c) **Crying**

630. **An 18 year old 26 week pregnant woman who uses illicit drugs frequently, the factors in risk for which one of the following:**

- a) Spina bifida
- b) Meconium aspiration
- c) Pneumonia
- d) **Teratogenicity**

631. **Common minor disorder in pregnancy?**

- a) abdominal pain
- b) **heart burn**
- c) headache

632. **An unmarried young female admitted with ectopic pregnancy with her friend to hospital with complaints of abdominal pain. Her friend assisted a procedure and became aware of her pregnancy and when the family arrives to hospital, she reveals the truth. The family reacts negatively. What could the nurse have done to protect the confidentiality of the patient information?**

- a. should tell the family that they don't have any rights to know the patient information
- b. that the friend was mistaken and the doctor will confirm the patient's condition

- c. should insist friend on confidentiality
- d. **should have asked another staff nurse to be a chaperone while assisting a procedure**

633. **Jenny was admitted to your ward with severe bleeding after 48 hours following her labour. What stage of post partum haemorrhage is she experiencing?**

- a) Primary
- b) **Secondary**
- c) Tertiary
- d) Emergency

634. **Postpartum haemorrhage: A patient gave birth via NSD. After 48 hours, patient came back due to bleeding, bleeding after birth is called post partum haemorrhage. What type?**

- A. primary postpartum haemorrhage
- B. **secondary postpartum haemorrhage**
- C. tertiary postpartum haemorrhage
- D. lochia

635. **A young mother who delivered 48hrs ago comes back to the emergency department with post partum haemorrhage. What type of PPH is it?**

- a) primary post partum haemorrhage
- b) **secondary post partum haemorrhage**
- c) tertiary post partum haemorrhage.

636. **A new mother is admitted to the acute psychiatric unit with severe postpartum depression. She is tearful and states, "I don't know why this happened to me I was so excited for my baby to come, but now I don't know!" Which of the following responses by the nurse is MOST therapeutic?**

- a) Maybe you weren't ready for a child after all."
- b) **Having a new baby is stressful, and the tiredness and different hormone levels don't help. It happens to many new mothers and is very treatable.**
- c) What happened once you brought the baby home? Did you feel nervous?
- d) Has your husband been helping you with the housework at all?"

637. **In a G.P clinic when you assessing a pregnant lady you observe some bruises on her hand. When you asked her about this she remains silent. What is your action?**

- a) Call her husband to know what is happening
- b) **Tell her that you are concerned of her welfare and you may need to share this information appropriately with the people who offer help**

- c) Do nothing as she does not want to speak anything
- d) Call the police

638. Which of the following best describes the Contingency Theory of Leadership?

- a) Leaders behaviour influence team members
- b) Leaders grasp the whole picture and their respective roles
- c) The plan is influenced by the outside force
- d) The leader sees the kind of situation, the setting, and their roles

639. Which of the major theories of aging suggest that older adults may decelerate the aging process?

- a) Disengagement theory
- b) Activity theory
- c) Immunology theory
- d) Genetic theory

640. Which of the steps is NOT involved in Tuckman's group formation theory?

- a) Accepting
- b) Norming
- c) Storming
- d) Forming

641. Which is not a stage in the Tuckman Theory of contingency?

- a) Forming
- b) Storming
- c) Norming
- d) Analysing

642. Which of the following nursing theorists developed a conceptual model based on the belief that all persons should strive to achieve self-care?

- a) Martha Rogers
- b) Dorothea Orem
- c) Florence Nightingale
- d) Cister Callista Roy

643. The contingency theory of management moves the manager away from which of the following approaches?

- a) No perfect solution
- b) One size fits all
- c) Interaction of the system with the environment

- d) a method of combination of methods that will be most effective in a given situation.

644. Which nursing delivery model is based on a production and efficiency model and stresses a task-orientated approach?

- a) Case management
- b) Primary nursing
- c) Differentiated practice
- d) Functional method

645. C Clostridium difficile (C- diff) infections can be prevented by:

- a) using hand gels
- b) washing your hands with soap and water
- c) using repellent gowns
- d) limit visiting times

646. Causes of diarrhoea in Clostridium Difficile are:

- a) Ulcerative colitis - Ulcerative Colitis is a condition that causes inflammation and ulceration of the inner lining of the rectum and colon
- b) Hashimotos disease - Hashimoto's disease, also called chronic lymphocytic thyroiditis or autoimmune thyroiditis, is an autoimmune disease
- c) Pseudomembranous colitis -pseudomembranous colitis (PMC) is an acute, exudative colitis usually caused by Clostridium difficile. PMC can rarely be caused by other bacteria,
- d) Crohn's disease - Crohn's Disease is one of the two main forms of Inflammatory Bowel Disease, so may also be called 'IBD'. The other main form of IBD is a condition known as Ulcerative Colitis

647. Barrier Nursing for C.diff patient what should you not do?

- a) Use of hand gel/ alcohol rub
- b) Use gloves
- c) Patient has his own set of washers
- d) Strict disinfection of pt's room after isolation

648. Leonor, 72 years old patient is being treated with antibiotics for her UTI. After three days of taking them, she developed diarrhoea with blood stains. What is the most possible reason for this?

- a) Antibiotics causes chronic inflammation of the intestine
- b) An anaphylactic reaction
- c) Antibiotic alters her GI flora which made Clostridium-difficile to multiply
- d) she is not taking the antibiotics with food

**649. You are caring for a patient in isolation with suspected Clostridium difficile. What are the essential key actions to prevent the spread of infection?**

- a) Regular hand hygiene and the promotion of the infection prevention link nurse role.
- b) Encourage the doctors to wear gloves and aprons, to be bare below the elbow and to wash hands with alcohol hand rub. Ask for cleaning to be increased with soap-based products.
- c) seek the infection prevention team to review the patient's medication chart and provide regular teaching sessions on the 5 moments of hand hygiene. Provide the patient and family with adequate information.
- d) Review antimicrobials daily, wash hands with soap and water before and after each contact with the patient, ask for enhanced cleaning with chlorine-based products and use gloves and aprons when disposing of body fluids.

**650. When treating patients with clostridium difficile, how should you clean your hands?**

- a) Use alcohol hand rubs
- b) Use soap & water
- c) Use hand wipes
- d) All of the above

**651. What infection control steps should not be taken in a patient with diarrhoea caused by Clostridium Difficile?**

- a) Isolation of the patient
- b) All staff must wear aprons and gloves while attending the patient
- c) All staff will be required to wash their hands before and after contact with the patient, their bed linen and soiled items
- d) Oral administration of metronidazole, vancomycin, fidaxomicin may be required
- e) None of the above

**652. Patient with clostridium deficile has stools with blood and mucus. due to which condition?**

- a) Ulcerative colitis
- b) Chrons disease
- c) Inflammatory bowel disease

**653. For which of the following modes of transmission is good hand hygiene a key preventative measure?**

- a) Airborne
- b) Direct & indirect contact

- c) Droplet
- d) \*All of the above

654. **5 moments of hand hygiene include all of the following except:**

- a) Before Patient Contact
- b) Before a clean / aseptic procedure
- c) Before Body Fluid Exposure Risk
- d) After Patient contact
- e) After Contact with Patient's surrounding

655. **If you were asked to take 'standard precautions' what would you expect to be doing?**

- A. Wearing gloves, aprons and mask when caring for someone in protective isolation
- B. Taking precautions when handling blood and 'high risk' body fluids so as not to pass on any infection to the patient
- C. Using appropriate hand hygiene, wearing gloves and aprons where necessary, disposing of used sharp instruments safely and providing care in a suitably clean environment to protect yourself and the patients
- D. Asking relatives to wash their hands when visiting patients in the clinical setting

656. **Define standard precaution:**

- A. The precautions that are taken with all blood and 'high-risk' body fluids.
- B. The actions that should be taken in every care situation to protect patients and others from infection, regardless of what is known of the patient's status with respect to infection.
- C. It is meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources.
- D. The practice of avoiding contact with bodily fluids, by means of wearing of nonporous articles such as gloves, goggles, and face shields.

657. **Except which procedure must all individuals providing nursing care must be competent at?**

- a) Hand hygiene
- b) Use of protective equipment
- c) Disposal of waste
- d) Aseptic technique

658. **Which client has the highest risk for a bacteraemia?**

- A. Client with a peripherally inserted central catheter (PICC) line
- B. Client with a central venous catheter (CVC)
- C. Client with an implanted infusion port
- D. Client with a peripherally inserted intravenous line

**659. In infection control, what is a pathogen?**

- A) A micro-organism that is capable of causing infection, especially in vulnerable individuals, but not normally in healthy ones.
- B) Micro-organisms that are present on or in a person but not causing them any harm.
- C) Indigenous microbiota regularly found at an anatomical site.
- D) Antibodies recruited by the immune system to identify and neutralize foreign objects like bacteria and viruses.

**660. When disposing of waste, what colour bag should be used to dispose of offensive/ hygiene waste?**

- a) Orange
- b) Yellow
- c) Yellow and black stripe
- d) Black

**661. Before giving direct care to the patient, u should**

- A) Wear mask, aprons
- B) Wash hands with alchohol rub
- C) Handwashing using 6 steps
- D) Take all standard precautions

**662. What infection is thought to be caused by prions?**

- a) Leprosy
- b) Pneumocystis jirovecii
- c) Norovirus
- d) Creutzfeldt Jakob disease
- e) None of the above

**663. For which of the following modes of transmission is good hand hygiene a key preventative measure?**

- A. Airborne
- B. Direct contact
- C. Indirect contact
- D. All of the above

**664. If a patient requires protective isolation, which of the following should you advise them to drink?**

- a) Filtered water only
- b) Fresh fruit juice and filtered water
- c) Bottled water and tap water
- d) Tap water only
- e) long-life fruit juice and filtered water

665. **Examples of offensive/hygiene waste which may be sent for energy recovery at energy from waste facilities can include:**

- a) Stoma or catheter bags - The Management of Waste from health, social and personal care -RCN
- b) Unused non-cytotoxic/cytostatic medicines in original packaging
- c) Used sharps from treatment using cytotoxic or cytostatic medicines
- d) Empty medicine bottles

666. **The use of an alcohol-based hand rub for decontamination of hands before and after direct patient contact and clinical care is recommended when:**

- a) Hands are visibly soiled
- b) Caring for patients with vomiting or diarrhoeal illness, regardless of whether or not gloves have been worn
- c) Immediately after contact with body fluids, mucous membranes and non-intact skin

667. **You are told a patient is in "source isolation". What would you do & why?**

- a) Isolating a patient so that they don't catch any infections
- b) Nursing an individual who is regarded as being particularly vulnerable to infection in such a way as to minimize the transmission of potential pathogens to that person.
- c) Nursing a patient who is carrying an infectious agent that may be risk to others in such a way as to minimize the risk of the infection spreading elsewhere in their body.
- d) Nurse the patient in isolation, ensure that you wear appropriate personal protective equipment (PPE) & adhere to strict hygiene, for the purpose of preventing the spread of organism from that patient to others.

668. **If you were told by a nurse at handover to take "standard precautions" what would you expect to be doing?**

- a) Taking precautions when handling blood & 'high risk' body fluids so that you don't pass on any infection to the patient.
- b) Wearing gloves, aprons & mask when caring for someone in protective isolation to protect yourself from infection
- c) Asking relatives to wash their hands when visiting patients in the clinical setting

- d) Using appropriate hand hygiene, wearing gloves & aprons when necessary, disposing of used sharp instruments safely & providing care in a suitably clean environment to protect yourself & the patients

669. Under the Yellow Card Scheme you must report the following: ( Select x 2 correct answers)

- a) Faulty brakes on a wheelchair
- b) Suspected side effects to blood factor, except immunoglobulin products
- c) Counterfeit or fake medicines or medical devices

670. Where will you put infectious linen?

- a) red plastic bag designed to disintegrate when exposed to heat
- b) red linen bag designed to hold its integrity even when exposed to heat
- c) yellow plastic bag for disposal

671. What would make you suspect that a patient in your care had a urinary tract infection?

- a) The doctor has requested a midstream urine specimen.
- b) The patient has a urinary catheter in situ, and the patients wife states that he seems more forgetful than usual.
- c) The patient has spiked a temperature, has a raised white cell count (WCC), has new-onset confusion and the urine in his catheter bag is cloudy.
- d) The patient has complained of frequency of faecal elimination and hasn't been drinking enough.

672. Which of the following would indicate an infection?

- a) Hot, sweaty, a temperature of 36.5°C, and bradycardic.
- b) Temperature of 38.5°C, shivering, tachycardia and hypertensive.
- c) Raised WBC, elevated blood glucose and temperature of 36.0°C.
- d) Hypotensive, cold and clammy, and bradycardic.

673. A client was diagnosed to have infection. What is not a sign or symptom of infection?

- a) A temperature of more than 38°C
- b) warm skin
- c) Chills and sweats
- d) Aching muscles

674. Mrs. Smith is receiving blood transfusion after a total hip replacement operation. After 15 minutes, you went back to check her vital signs and she complained of high temperature and loin pain. This may indicate:

- a) Renal Colic

- b) Urine Infection
- c) Common adverse reaction
- d) **Serious adverse reaction**

675. **As an infection prevention and control protocol, linens soiled with infectious bodily fluids should be disposed of in what means?**

- a) **Placed in yellow plastic bag to be disposed of**
- b) **Placed in dissolvable red linen bag and washed at high temperature**
- c) Placed in yellow linen bag, and washed at high temperature
- d) Placed in red plastic bag to be incinerated at high temperature

676. **What percentage of patients in hospital in England, at the time of the 2011 National Prevalence survey, had an infection?**

- a) 4.6%
- b) **6.4%**
- c) 14%
- d) 16%

677. **How to take an infected sheet for washing according to UK standard**

- a) Take infected linen in yellow bag for disposal
- b) Take in red plastic bag, that disintegrates in high temperature
- c) **Use red linen bag that allows washing in high temperatures**
- d) Use a white bag

678. **There has been an outbreak of the Norovirus in your clinical area. Majority of your staff have rang in sick. Which of the following is incorrect?**

- a.) Do not allow visitors to come in until after 48h of the last episode
- b.) Tally the episodes of diarrhoea and vomiting
- c.) Staff who has the virus can only report to work 48h after last episode
- d.) **Ask one of the staff who is off-sick to do an afternoon shift on same day**

679. **Infected linen should be placed in:**

- a) **Red plastic bag that disintegrates at high temperature**
- b) Red linen bag that can withstand high temperatures
- c) White linen bag that can withstand high temperatures
- d) Yellow plastic bag that cannot withstand high temperatures.

680. **When do you wear clean gloves?**

- a) Assisting with bathing
- b) Feeding a client
- c) **When there is broken skin on hand**

d) Any activity which includes physical touch of a client

681. The nurse needs to validate which of the following statements pertaining to an assigned client?

- a) The client has a hard, raised, red lesion on his right hand.
- b) A weight of 185 lbs. is recorded in the chart
- C. The client reported an infected toe
- D. The client's blood pressure is 124/70. It was 118/68 yesterday.

682. When explaining about travellers' diarrhoea which of the following is correct?

- a) Travellers' diarrhoea is mostly caused by Rotavirus
- b) Antimotility drugs like loperamide is ineffective management
- c) Oral rehydration in adults and children is not useful
- d) Adsorbents such as kaolin is ineffective and not advised

683. Which bag do you place infected linen?

- a) water-soluble alginate polythene bag before being placed in the appropriate linen bag, no more than  $\frac{3}{4}$  full
- b) orange waste bag, before being placed in the appropriate linen bag, no more than  $\frac{3}{4}$  full
- c) white linen bag, after sorting, no more than  $\frac{3}{4}$  full

684. One of your patients in bay 1 having episodes of vomiting in the last 2 days now. The Norovirus alert has been enforced. The other patients look concerned that he may spread infection. What is your next action in the situation?

- a) Seek the infection control nurse's advice regarding isolation
- b) Give the patient antiemetic to control the vomiting
- c) Offer the patient a lot of drinks to rehydrated
- d) Tell the other patients that vomiting will not cause infection to others

685. Under the Yellow Card Scheme you must report the following: ( Select x 2 correct answers)

- A. Faulty brakes on a wheelchair
- B. Suspected side effects to blood factor, except immunoglobulin products
- C. Counterfeit or fake medicines or medical devices
- D. Ascites and increased vascular pattern on the skin

686. For which type of waste should orange bags be used?

- a) Waste that requires disposal by incineration
- b) Offensive/hygiene waste
- c) \*Waste which may be 'treated
- d) Offensive waste

687. **Jenny, a nursing assistant working with you in an Elderly Care Ward is showing signs of norovirus infection. Which of the following will you ask her to do next?**

- A. Go home and avoid direct contact with other people and preparing food for others until at least 48 hours after her symptoms have disappeared
- B. Disinfect any surfaces or objects that could be contaminated with the virus
- C. Flush away any infected faeces or vomit in the toilet and clean the surrounding toilet area
- D. Avoid eating raw oysters

688. **Mrs X had developed Steven-Johnson syndrome whilst on Carbamazepine. She is now being transferred for the ITU to a bay in the Medical ward. Which patient can Mrs X share a baby with?**

- a) a patient with MRSA
- b) a patient with diarrhoea
- c) a patient with a fever of unknown origin
- d) a patient with Stephen Johnson Syndrome

689. **Which of the following are not signs of a speed shock?**

- a) Flushed face
- b) Headache and dizziness
- c) Tachycardia and fall in blood pressure
- d) Peripheral oedema

690. **Which is not a sign or symptom of speed shock?**

- A. Headache
- B. A tight feeling in the chest
- C. Irregular pulse
- D. Cyanosis

691. **What are the signs and symptoms of shock during early stage (stage 1-3)?**

- a) hypoxemia
- b) tachycardia and hyperventilation
- c) hypotension
- d) acidosis

692. **All but one are signs of anaphylaxis:**

- A. itchy skin or a raised, red skin rash
- B. swollen eyes, lips, hands and feet
- C. **hypertension and tachycardia**
- D. abdominal pain, nausea and vomiting

693. Which of the following are signs of anaphylaxis?

- a) swelling of tongue and rashes
- b) **dyspnoea, hypotension and tachycardia**
- c) hypertension and hyperthermia
- d) cold and clammy skin

694. You were asked by the nursing assistant to see Claudia whom you have recently given trimetophrim 200 mgs PO because of urine infection. When you arrived at her bedside, she was short of breath, wheezy and some red patches evident over her face. Which of the following actions will you do if you are suspecting anaphylaxis?

- a) call for help and give oxygen
- b) give oxygen and salbutamol nebs if prescribed and call for help
- c) give oxygen, administer adrenaline 500 mcg IM, give salbutamol nebs if prescribed and call for help
- d) **call for help, give oxygen, administer adrenaline 500 mcg IM, give salbutamol nebs if prescribed.**

695. A patient has collapsed with an anaphylactic reaction. What symptoms would you expect to see?

- a) The patient will have a low blood pressure (hypotensive) and will have a fast heart rate (tachycardia) usually associated with skin and mucosal changes.
- b) The patient will have a high blood pressure (hypertensive) and will have a fast heart rate (tachycardia).
- c) **The patient will quickly find breathing very difficult because of compromise to their airway or circulation. This is accompanied by skin and mucosal changes**
- d) The patient will experience a sense of impending doom, hyperventilate and be itchy all over

696. What are the signs and symptoms of shock during early stage (stage 1-3)? (CHOOSE 3 ANSWERS)

- A. **hypoxemia**
- B. **tachycardia and hyperventilation**
- C. **hypotension**
- D. Acidosis

697. After lumbar puncture, the patient experienced shock. What is the etiology behind it?
- a) Increased ICP
  - b) Headache
  - c) Side effect of medications
  - d) CSF leakage
698. A patient has collapsed with an anaphylactic reaction. What symptoms would you expect to see?
- a) The patient will have a low blood pressure (hypotensive) & will have a fast heart rate (tachycardia) usually associated with skin & mucosal changes
  - b) The patient will have a high blood pressure (hypertensive) & will have a fast heart rate (tachycardia)
  - c) The patient will quickly find breathing very difficult because of compromise to their airway or circulation. This is accompanied by skin & mucosal changes
  - d) The patient will experience a sense of impending doom, hyperventilate & be itchy all over
699. Leonor, 72 years old patient is being treated with antibiotics for her UTI. After three days of taking them, she developed diarrhoea with blood stains. What is the most possible reason for this?
- a) Antibiotics causes chronic inflammation of the intestine
  - b) An anaphylactic reaction
  - c) Antibiotic alters her GI flora which made Clostridium-difficile to multiply
  - d) she is not taking the antibiotics with food
700. The following are signs & symptoms of hypovolemic shock, except:
- A. Confusion
  - B. Rapid heart rate
  - C. Strong pulse
  - D. Decrease Blood Pressure
701. While giving an IV infusion your patient develops speed shock. What is not a sign and symptom of this?
- A. Circulatory collapse
  - B. Peripheral oedema
  - C. Facial flushing
  - D. Headache
702. Signs and symptoms of septic shock?
- a) Tachycardia, hypertension, normal WBC, non pyrexial
  - b) Tachycardia, hypotension, increased WBC, pyrexial
  - c) Tachycardia, , increased WBC, normotension, non pyrexial

d) Decreased heart rate, decreased blood pressure, normal WBC and pyrexial

703. Which of the following is not a criteria for anaphylactic reaction:

- a) Sudden onset and rapid progression of symptoms
- b) life threatening airway and/ or breathing and/or circulation problems
- c) skin and/or mucosal changes ( flushing, urticaria and angioedema)
- d) skin and mucosal changes only
- e) A and B only
- f) all of the above
- e) A, B and C

704. Signs of hypovolemic shock would include all except:

A. restlessness, anxiety or confusion



B. shallow respiratory rate, becoming weak

C. rising pulse rate

D. low urine output of <0.5 mL/kg/h E. pallor (pale, cyanotic skin) and later sweating

705. An Eight year old girl with learning disabilities is admitted for a minor surgery, she is very restless and agitated and wants her mother to stay with her, what will you do?

- A. Advice the mother to stay till she settles.
- b. Act according to company policy
- c. Tell her you will take care of the child
- d. Inform the Doctor

706. What is meant by 'Gillick competent'?

A. Children under the age of 12 who are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.

\*B. Children under the age of 16 who are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment

C. Children under the age of 18 who are believed not to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.

D. Children under the lawful age of consent who are believed not to have enough intelligence, competence and understanding to

707. When communicating with children, what most important factor should the nurse take into consideration?

a) Developmental level

- b) Physical development
- c) Nonverbal cues
- d) Parental involvement

708. Normal heart rate for 1 to 2 years old?

- a) 80 - 140 beats per minute
- b) 80 - 110 beats per minute
- c) 75 - 115 beats per minute

709. Which of the following is an average heart rate of a 1-2 year old child?

- a) 110-120 bpm
- b) 60-100 bpm
- c) 140-160 bpm
- d) 80-120 bpm

710. You are assisting a doctor who is trying to assess and collect information from a child who does not seem to understand all that the doctor is telling and is restless. What will be your best response?

- a) Stay quiet and remain with the doctor
- b) Interrupt the doctor and ask the child the questions
- c) Remain with the doctor and try to gain the confidence of the child and politely assess the child's level of understanding and help the doctor with the information he is looking for
- d) Make the child quiet & ask his mother to stay with him

711. Recognition of the unwell child is crucial. The following are all signs and symptoms of respiratory distress in children EXCEPT:

- a) Lying supine
- b) Nasal flaring
- c) Intercostal and sternal recession
- d) adopting an upright position

712. As you visit your patient during rounds, you notice a thin child who is shy and not mingling with the group who seemed to be visitors of the patient. You offered him food but his mother told you not to mind him as he is not eating much while all of them are eating during that time. As a nurse, what will you do?

- a) inform social service desk on suspected case of child neglect
- b) ignore incident since the child is under the responsibility of the mother
- c) raise the situation to your head nurse and discuss with her what intervention might be done to help the child

713. Recognition of the unwell child is crucial. The following are all signs and symptoms of respiratory distress in children EXCEPT:

- A. Lying supine
- B. Nasal flaring
- C. Intercostal and sternal recession
- D. adopting an upright position

714. **There is a child you are taking care of at home who has a history of anaphylactic shock from certain foods, the nurse is feeding him lunch, he looks suddenly confused, breathless and acting different, the nurse has access to emergency drugs access and the mobile phone, what will she do?**

- a) She will keep the child awake by talking to him and call 911 for help
- b) **She will raise the child's legs and administer Adrenaline and call the emergency services**
- c) The nurse will keep the child in standing position and try to reassure the child

715. **You are about to administer Morphine Sulfate to a paediatric patient. The information written on the controlled drug book was not clearly written – 15 mg or 0.15 mg. What will you do first?**

- a. Not administer the drug, and wait for the General Practitioner to do his rounds
- b. Administer 0.15 mg, because 15 mg is quite a big dose for a paediatric patient
- c. **Double check the medication label and the information on the controlled drug book; ring the chemist to verify the dosage**
- d. Ask a senior staff to read the medication label with you

716. **When communicating with children, what most important factor should the nurse take into consideration?**

- a) **Developmental level**
- b) Physical development
- c) Non verbal cues
- d) Parental involvement

717. **Management of moderate malnutrition in children?**

- a) supplementary nutrition
- b) immediate hospitalization
- c) weekly assessment
- d) **document intake for three days**

718. **You saw a relative of a client has come with her son, who looks very thin, shy & frightened. You serve them food, but the mother of that child says "don't give him, he eats too much". You should:**
- a) **Raise your concern with your nurse manager about potential for child abuse & ask for her support**
  - b) Ignore the mother & ask the relative if the child is abused.
  - c) Ignore the mother's advice & serve food to the child.
  - d) Ignore the situation as she is the mother & knows better about her child.
719. **U just joined in a new hospital. U see a senior nurse beating a child with learning disability. Ur role**
- a) Neglect the situation as u r new to the scenario
  - b) **Intervene at the spot, speak directly to the senior in a non-confronting manner, and report to management in writing**
  - c) Inform the ward in-charge after the shift
720. **A nurse finds it very difficult to understand the needs of a child with learning disability. She goes to other nurses and professionals to seek help. How u interpret this action**
- a) The nurse is short of self confidence
  - b) **A nurse, who is well aware of her limitations seeked help from others. She worked within her competency.**
  - c) She doesn't have the kind of courage a nurse should have
721. **A nurse notices a thin emaciated child among the family members of a patient. The child is weak and withdrawn. When nurse offers some food to child, mother says do not give as he eats too much. Nurses response**
- a) Mother needs to take care of her child. So neglect the situation
  - b) Ask family members about child abuse
  - c) Call the local police for help
  - d) **Inform the manager about suspected child neglect and seek support**
722. **Monica is going to receive blood transfusion. How frequently should we do her observation?**
- A) Temperature and Pulse before the blood transfusion begins, then every hour, and at the end of bag/unit
  - B) **Temperature, pulse, blood pressure and respiration before the blood transfusion begins, then after 15 min, then as indicated in local guidelines, and finally at the end of bag/unit.**
  - C) Temperature, pulse, blood pressure and respiration and urinalysis before the blood transfusion, then at end of bag.
  - D) Pulse, blood pressure and respiration every hour, and at the end of the bag

723. A mentally capable client in a critical condition is supposed to receive blood transfusion. But client strongly refuses the blood product to be transfused. What would be the best response of the nurse?
- a) Accept the client's decision and give information on the consequences of his actions
  - b) Let the family decide
  - c) Administer the blood product against the patients decision
  - d) The doctor will decide
724. Fred is going to receive a blood transfusion. How frequently should we do his observations?
- a) Temperature and pulse before the blood transfusion begins, then every hour, and at the end of bag/unit.
  - b) Temperature, pulse, blood pressure and respiration before the blood transfusion begins, then after 15 minutes, then as indicated in local guidelines, and finally at the end of the bag/unit.
  - c) Temperature, pulse, blood pressure and respiration and urinalysis before the blood transfusion, then at end of bag.
  - d) Pulse, blood pressure and respiration every hour, and at the end of the bag.
725. Patient developed elevated temperature and pain in the loin during blood transfusion. This is indicative of:
- a) Severe blood transfusion reaction
  - b) Common blood transfusion reaction
726. Mrs. Smith is receiving blood transfusion after a total hip replacement operation. After 15 minutes, you went back to check her vital signs and she complained of high temperature and loin pain. This may indicate:
- a) Renal Colic
  - b) Urine Infection
  - c) Common adverse reaction
  - d) Serious adverse reaction
727. During blood transfusion, a patient develops pyrexia, and loin pain. Rn interprets the situation as
- a) Common reaction to transfusion
  - b) Adverse reaction to blood transfusion
  - c) Patient has septicaemia
728. What are the steps of the nursing Process?
- A. Assessing, diagnosing, planning, implementing, and evaluating
  - B. Assessing, planning, implementing, evaluating, documenting
  - C. Assessing, observing, diagnosing, planning, evaluating

D. Assessing, reacting, implementing, planning, evaluating

**729. What is clinical benchmarking?**

- A. The practice of being humble enough to admit that someone else is better at something and being wise enough to try to learn how to match and even surpass them at it.
- B. A systematic process in which current practice and care are compared to, and amended to attain, best practice and care
- C. A system that provides a structured approach for realistic and supportive practice development
- D. **All of the above**

**730. Where is revision on the nursing process done? During:**

- a) Diagnosis
- b) Planning
- c) Implementation
- d) **Evaluation**

**731. What does intermediate care not consist of?**

- a) **Maximise dependent living**
- b) Prevent unnecessary acute hospital admission
- c) Prevent premature admission to long-term residential care
- d) Support timely discharge from hospital

**732. A nurse documents vital signs without actually performing the task. Which action should the charge nurse take after discussing the situation with the nurse?**

- a) Charge the nurse with malpractice
- b) **Document the incident**
- c) Notify the board of nursing
- d) Terminate employment

**733. The nurse has made an error in documenting client care. Which appropriate action should the nurse take?**

- a) **Draw a line through error, initial, date and document correct information**
- b) Document a late addendum to the nursing note in the client's chart
- c) Tear the documented note out of the chart
- d) Delete the error by using whiteout

**734. Hospital discharge planning for a patient should start:**

- A. When the patient is medically fit
- B. **On the admission assessment**
- C. When transport is available

735. **What is comprehensive nursing assessment?**

- a) It provides the foundation for care that enables individuals to gain greater control over their lives and enhance their health status.
- b) **An in-depth assessment of the patient's health status, physical examination, risk factors, psychological and social aspects of the patient's health that usually takes place on admission or transfer to a hospital or healthcare agency.**
- c) An assessment of a specific condition, problem, identified risks or assessment of care; for example, continence assessment, nutritional assessment, neurological assessment following a head injury, assessment for day care, outpatient consultation for a specific condition.
- d) It is a continuous assessment of the patient's health status accompanied by monitoring and observation of specific problems identified.

736. **When do you plan a discharge?**

- a) **24 hrs within admission**
- b) 72 hrs within admission
- c) 48 hrs within admission
- d) 12 hrs within admission

737. **All but one describes holistic care:**

- A. A system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs.
- B. It embraces all nursing practice that has enhancement of healing the whole person from birth to death as it's goals.
- C. **An all nursing practice that has healing the person as its goal.**
- D. It involves understanding the individual as a unitary whole in mutual process with the environment.

738. **Nursing process is best illustrated as:**

- A. Patient with medical diagnosis
- B. task oriented care
- C. **Individualized approach to care**
- D. All of the above

739. **Which statement is not correct about the nursing process?**

- a) An organised, systematic and deliberate approach to nursing with the aim of improving standards in nursing care.
- b) It uses a systematic, holistic, problem solving approach in partnership with the patient and their family.
- c) It is a form of documentation.
- d) **It requires collection of objective data.**

740. Which of the following sets of needs should be included in your service user's person centred care plan?

- a) social, spiritual and academic needs
- b) medical, psychological and financial needs
- c) physical, medical, social, psychological and spiritual needs
- d) a and b only
- e) all of the above?

741. A nurse explains to a student that the nursing process is a dynamic process. Which of the following actions by the nurse best demonstrates this concept during the work shift?

- a) Nurse and client agree upon health care goals for the client
- b) Nurse reviews the client's history on the medical record
- c) Nurse explains to the client the purpose of each administered medication
- d) Nurse rapidly reset priorities for client care based on a change in the client's condition

742. The nursing process involves the following:

- a) assessment, diagnosis, planning, intervention and evaluation
- b) assessment, differentiation, planning, intervention, evaluation
- c) assessment, planning, intervention, evaluation
- d) assessment, planning, referring, evaluation

743. The rehabilitation nurse wishes to make the following entry into a client's plan of care: "Client will reestablish a pattern of daily bowel movements without straining within two months." The nurse would write this statement under which section of the plan of care?

- A) Long-term goals
- B) Short-term goals
- C) Nursing orders
- D) Nursing diagnosis/problem list

744. Nursing process is best illustrated as:

- a) Patient with medical diagnosis
- b) task oriented care
- c) Individualized approach to care
- d) All of the above

745. What does intermediate care not consist of?

- A. Maximise dependent living
- B. Prevent unnecessary acute hospital admission

- C. Prevent premature admission to long-term residential care
- D. Support timely discharge from hospital

746. **In caring for a patient, the nurse should?**

- A) whenever possible provide care that is culturally sensitive and according to patients preference
- B) ask the patient and their family about their culture
- C) be aware of the patient's culture
- D) disregard the patient's culture

747. **All individuals providing nursing care must be competent at which of the following procedures?**

- a) Hand hygiene and aseptic technique
- b) Aseptic technique only
- c) Hand hygiene, use of protective equipment, and disposal of waste
- d) Disposal of waste and use of protective equipment
- e) All of the above

748. **Nursing care should be**

- a) Task oriented
- b) Caring medical and surgical patient
- c) Patient oriented, individualistic care
- d) All

749. **The client reports nausea and constipation. Which of the following would be the priority nursing action?**

- A. Collect a stool sample
- B. Complete an abdominal assessment
- C. Administer an anti-nausea medication
- D. Notify the physician

750. **Hospital discharge planning for a patient should start:**

- a) When the patient is medically fit
- b) On the admission assessment
- c) When transport is available

751. **Which of the following descriptors is most appropriate to use when stating the "problem" part of nursing diagnosis?**

- a) Oxygenation saturation 93%

- b) Output 500 ml in 8 hours
- c) Anxiety
- d) Grimacing

752. **When do you see problems or potential problems?**

- A. Assessment
- B. Planning
- C. Implementation
- D. Evaluation

753. **A walk-in client enters into the clinic with a chief complaint of abdominal pain and diarrhea. The nurse takes the client's vital sign hereafter. What phrase of nursing process is being implemented here by the nurse?**

- A) Assessment
- B) Diagnosis
- C) Planning
- D) Implementation

754. **How do you value dignity & respect in nursing care? Select which does not apply:**

- A. We value every patient, their families or carers, or staff.
- B. We respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits.
- C. We find time for patients, their families and carers, as well as those we work with.
- D. We are honest and open about our point of view and what we can and cannot do.

755. **Which of the following items of subjective client data would be documented in the medical record by the nurse?**

- A. Client's face is pale
- B. Cervical lymph nodes are palpable
- C. Nursing assistant reports client refused lunch
- D. Client feel nauseated

756. **How the nurse assesses the quality of care given**

- A) reflective process
- b) clinical bench marking
- c) peer and patient response
- d) all the above

757. **Which of the following items of subjective client data would be documented in the medical record by the nurse?**

- A. Client's face is pale
- B. Cervical lymph nodes are palpable
- C. Nursing assistant reports client refused lunch
- D. **Client feel nauseated**

758. Which of the following descriptors is most appropriate to use when stating the "problem" part of a nursing diagnosis?

- A. Grimacing
- B. **Anxiety**
- C. Oxygenation saturation 93%
- D. Output 500 mL in 8 hours

759. You can delegate medication administration to a student if:

- a) The student was assessed as competent
- b) **Only under close, direct supervision**
- c) The patient has only oral medication

760. What are the professional responsibilities of the qualified nurse in medicines management?

- a) Making sure that the group of patients that they are caring for receive their medications on time. If they are not competent to administer intravenous medications, they should ask a competent nursing colleague to do so on their behalf.
- b) **The safe handling and administration of all medicines to patients in their care. This includes making sure that patients understand the medicines they are taking, the reason they are taking them and the likely side effects.**
- c) Making sure they know the names, actions, doses and side effects of all the medications used in their area of clinical practice.
- d) To liaise closely with pharmacy so that their knowledge is kept up to date.

761. Who has the overall responsibility for the safe and appropriate management of controlled drugs within the clinical area?

- A. All registered nurses
- B. **The nurse in charge**
- C. The consultant
- D. All staff

762. What are the key reasons for administering medications to patients?

- a) To provide relief from specific symptoms, for example pain, and managing side effects as well as therapeutic purposes.
- b) **As part of the process of diagnosing their illness, to prevent an illness, disease or side effect, to offer relief from symptoms or to treat a disease**

- c) As part of the treatment of long term diseases, for example heart failure, and the prevention of diseases such as asthma.
- d) To treat acute illness, for example antibiotic therapy for a chest infection, and side effects such as nausea.

763. **What are the most common types of medication error?**

- a) Nurses being interrupted when completing their drug rounds, different drugs being packaged similarly and stored in the same place and calculation errors.
- b) Unsafe handling and poor aseptic technique.
- c) Doctors not prescribing correctly and poor communication with the multidisciplinary team.
- d) **Administration of the wrong drug, in the wrong amount to the wrong patient, via the wrong route**

764. **Registrants must only supply and administer medicinal products in accordance with one or more of the following processes, except:**

- a) **Carer specific direction (CSD)**
- b) Patient medicines administration chart (may be called medicines administration record MAR)
- d) **Patient group direction (PGD)**
- e) Medicines Act exemption

765. **Independent and supplementary nurse and midwife are those who are?**

- A. nurse and midwife student who cleared medication administration exam
- B. nurses and midwives educated in appropriate medication prescription for certain pharmaceuticals**
- C. registrants completed a programme to prescribe under community nurse practitioner's drug formulary
- D. nurses and midwives whose name is entered in the register

766. **As a RN when you are administering medication, you made an error. Taking health and safety of the patient into consideration, what is your action?**

- a) Call the prescriber. Report through yellow card scheme and document it in patient notes
- b) Let the next of kin know about this and document it
- c) Document this in patient notes and inform the line manager
- d) **Assess for potential harm to client, inform the line manager and prescriber and document in patient notes**

767. **You noticed that a colleague committed a medication administration error.**

**Which should be done in this situation?**

- A. You should provide a written statement and also complete a Trust incident form.

- B. You should inform the doctor.
- C. **You should report this immediately to the nurse in charge.**
- D. You should inform the patient.

**768. The nurses on the day shift report that the controlled drug count is incorrect. What is the most appropriate nursing action?**

- A. **Report the discrepancy to the nurse manager and pharmacy immediately**
- B. Report the incident to the local board of nursing
- C. Inform a doctor
- D. Report the incident to the NMC

**769. Which of the following is not a part of the 6 rights of medication administration?**

- A. Right time
- B. Right route
- C. Right medication
- D. **Right reason**

**770. A patient approached you to give his medications now but you are unable to give the medicine. What is your initial action?**

- a) Inform the doctor
- b) **Inform your team leader**
- c) Inform the pharmacist
- d) Routinely document meds not given

**771. On checking the stock balance in the controlled drug record book as a newly qualified nurse, you and a colleague notice a discrepancy. What would you do?**

- a) Check the cupboard, record book and order book. If the missing drugs aren't found, contact pharmacy to resolve the issue. You will also complete an incident form.
- b) Document the discrepancy on an incident form and contact the senior pharmacist on duty.
- c) Check the cupboard, record book and order book. If the missing drugs aren't found the police need to be informed.
- d) **Check the cupboard, record book and order book and inform the registered nurse or person in charge of the clinical area. If the missing drugs are not found then inform the most senior nurse on duty. You will also complete an incident form.**

**772. You are transcribing medications from prescription chart to a discharge letter. Before sending this letter what action must be taken?**

- a) **A registrant should sign this letter**
- b) Transcribing is not allowed in any circumstances

- c) The letter has to be checked by a nurse in charge
- d) Letter can be sent directly to the patient after transcribing

**773. Registrants must only supply and administer medicinal products in accordance with one or more of the following processes, except:**

- a. **Carer specific direction (CSD)**
- b. Patient medicines administration chart (may be called medicines administration record MAR)
- c. Patient group direction (PGD)
- d. Medicines Act exemption

**774. A patient recently admitted to hospital, requesting to self-administer the medication, has been assessed for suitability at Level 2 This means that:**

- a) The registrant is responsible for the safe storage of the medicinal products and the supervision of the administration process ensuring the patient understands the medicinal product being administered
- b) The patient accepts full responsibility for the storage and administration of the medicinal products
- c) **None of the above - The registrant is responsible for the safe storage of the medicinal products. At administration time, the patient will ask the registrant to open the cabinet or locker. The patient will then self-administer the medication under the supervision of the registrant**

**775. What are the potential benefits of self-administration of medicines by patients?**

- a) Nurses have more time for other aspects of patient care and it therefore reduces length of stay.
- b) **It gives patients more control and allows them to take the medications on time, as well as giving them the opportunity to address any concerns with their medication before they are discharged home.**
- c) Reduces the risk of medication errors, because patients are in charge of their own medication.
- d) Creates more space in the treatment room, so there are fewer medication errors

**776. A patient is rapidly deteriorating due to drug over dose what to do?**

- A. Assess ABCDE, call help, keep anaphylactic kit
- B. **Call for help, keep anaphylactic kit, assess ABCDE**
- C. Assess ABCDE, keep anaphylactic kit, inform doctor, call for help

**777. patient bring own medication to hospital and wants to self-administer what is your role ?  
allow him**

- e) give medications back to relatives to take back
- f) keep it in locker, use from medication trolley

g) explain to patient about medication before he administer it

**778. A client experiences an episode of pulmonary oedema because the nurse forgot to administer the morning dose of furosemide (Lasix). Which legal element can the nurse be charged with?**

- e) Assault
- f) Slander
- g) **Negligence**
- h) tort

**779. As a newly qualified nurse, what would you do if a patient vomits when taking or immediately after taking tablets?**

A. Comfort the patient, check to see if they have vomited the tablets, & ask the doctor to prescribe something different as these obviously don't agree with the patient

B. Check to see if the patient has vomited the tablets & if so, document this on the prescription chart. If possible, the drugs may be given again after the administration of antiemetics or when the patient no longer feels nauseous. It may be necessary to discuss an alternative route of administration with the doctor

C. In the future administer antiemetics prior to administration of all tablets

D. Discuss with pharmacy the availability of medication in a liquid form or hide the tablets in food to take the taste away.

**780. A newly admitted client refusing to handover his own medications and this includes controlled drugs. What is your action?**

- a) You have to take it any way and document it
- b) Call the doctor and inform about the situation
- c) **Document this refusal as these medications are his property and should not do anything without his consent**
- d) Refuse the admission as this is against the policy

**781. What medications would most likely increase the risk for fall?**

- a) Loop diuretic
- b) **Hypnotics**
- c) Betablockers
- d) Nsaids

**782. Tony is prescribed Lanoxin 500 mcg PO. What vital sign will you assess prior to giving the drug?**

- a) **heart rate and rhythm**
- b) respiration rate and depth
- c) temperature
- d) urine output

783. Patient has next dose of Digoxin but has a CR=58

- a) Omit dose, record why, and inform the doctor
- b) Give dose and tell the doctor
- c) Give dose as prescribed

784. Which drug to be avoided by a patient on digoxin?

- a) corticosteroid
- b) nsaid

785. Which of the following should be considered before giving digoxin?

- a) Allergies
- b) Drug interactions
- c) Other interactions with food or substances like alcohol and tobacco
- d) Medical problems (Thyroid problems, kidney disease, etc.)
- e) All of the above.

786. Which of these medications is not administer with digoxin?

- a) Diuretics
- b) Corticosteroids
- c) Antibiotics
- d) NSAID's

787. Which of the following should be considered before giving digoxin?

- 1. Allergies
- 2. Drug interactions
- 3. Other interactions with food or substances like alcohol and tobacco
- 4. Medical problems (Thyroid problem, Kidney disease, etc.)
- A. 1&2
- B. 3&4
- C. 1, 3, & 4
- D. All of the above

788. The nurse monitors the serum electrolyte level of a client who is taking digoxin. Which of the following electrolytes imbalances is common cause of digoxin toxicity?

- a) Hypocalcemia
- b) Hypomagnesemia
- c) Hypokalaemia
- d) Hyponatremia

789. Your patient has been prescribed Tramadol 50 mgs tablet for pain relief.

- a. Record this in the controlled drug register book with the pharmacist witnessing
- b. Put it in the patient's medicine pod
- c. Store it in ward medicine cupboard
- d. Ask the pharmacist to give it to the patient

790. You have been asked to give Mrs Patel her mid-day oral metronidazole. You have never met her before. What do you need to check on the drug chart before you administered?

- a) Her name and address, the date of the prescription and dose.
- b) Her name, date of birth, the ward, consultant, the dose and route, and that it is due at 12.00.
- c) Her name, date of birth, hospital number, if she has any known allergies, the prescription for metronidazole: dose, route, time, date and that it is signed by the doctor, and when it was last given
- d) Her name and address, date of birth, name of ward and consultant, if she has any known allergies specifically to penicillin, that prescription is for metronidazole: dose, route, time, date and that it is signed by the doctor, and when it was last given and who gave it so you can check with them how she reacted.

791. You are caring for a Hindu client and it's time for drug administration; the client refuses to take the capsule referring to the animal product that might have been used in its making, what is the appropriate action for the nurse to perform?

- a) She will not administer and document the omissions in the patients chart
- b) The nurse will ignore the clients request and administer forcebily
- c) The nurse will open the capsule and administer the powdered drug
- d) The nurse will establish with the pharamacist if the capsule is suitable for vegetarians

792. John, 18 years old is for discharge and will require further dose of oral antibiotics. As his nurse, which of the following will you advise him to do?

- a) Take with food or after meals and ensure to take all antibiotics as prescribed
- b) Take all antibiotics and as prescribed
- c) Take medicine during the day and ensure to finish the course of medication
- d) Take medicine and stop when he feels better

793. When should prescribed antibiotics to be administered to a septicemic patient

- a) Immediately after admission
- b) After getting blood culture result
- c) Immediately following blood drawn for culture

794. You are the named nurse of Colin admitted at Respiratory ward because of chest infection. His also suffers from Parkinson's syndrome. What

medications will you ensure Colin has taken on regular time to control his 'shaking'?

- a) Co-careldopa (Sinemet)
- b) Co-amoxiclave (augmentin)
- c) Co-codamol
- d) Co-Q10

795. **Your hospital supports the government's drive on breastfeeding. One of your patient being treated for urinary tract infection was visited by her husband and their 4 month old baby. She would like to breastfeed her baby. What advise will you give her?**

- a. it is ok to breastfeed as long as it is done privately
- b. it is ok to breastfeed because the hospital supports this practice
- c. refrain from breastfeeding as of now because of her UTI treatment
- d. breast milk is the best and she can feed her baby anytime they visit



796. **Describe the breathing pattern when a patient is suffering from Opioid toxicity:**

- A. Slow and shallow
- B. fast and shallow
- C. slow and deep
- D. Fast and deep

797. **What are the key nursing observations needed for a patient receiving opioids frequently?**

- a) Respiratory rate, bowel movement record and pain assessment and score.
- b) Checking the patient is not addicted by looking at their blood pressure.
- c) Lung function tests, oxygen saturations and addiction levels
- d) Daily completion of a Bristol stool chart, urinalysis, and a record of the frequency with which the patient reports breakthrough pain

798. **What advice do you need to give to a patient taking Allopurinol? (Select x 3 correct answers)**

- a) Drink 8 to 10 full glasses of fluid every day, unless your doctor tells you otherwise.
- b) Store allopurinol at room temperature away from moisture and heat.
- c) Avoid being near people who are sick or have infections
- d) Skin rash is a common side effect, it will pass after a few days

799. **What instructions should you give a client receiving oral Antibiotics?**

- a) Consume it all at once
- b) take the antibiotic with glass of water
- c) Take the medication with meals and consume all the antibiotics

**d) take the medication as prescribed and complete the course**

**800. When the doc will prescribe a broad-spectrum antibiotic?**

A) on admission

**B) when septicemia is suspected**

C) when the blood culture shows positive growth of organism

**801. After two weeks of receiving lithium therapy, a patient in the psychiatric unit becomes depressed. Which of the following evaluations of the patient's behavior by the nurse would be MOST accurate?**

a) The treatment plan is not effective; the patient requires a larger dose of lithium.

**b) This is a normal response to lithium therapy; the patient should continue with the current treatment plan.**

c) This is a normal response to lithium therapy; the patient should be monitored for suicidal behavior.

d) The treatment plan is not effective; the patient requires an antidepressant

**802. Johan, 25 year old, was admitted at Medical Assessment Unit because of urine infection. During your assessment, he admitted using cannabis under prescription for his migraine and still have some in his bag. What is your best reply to him about the cannabis?**

a) Cannabis is a class C drug under the UK Misuse of Drugs Act 1971.

b) A custodial sentence of 28 days is now given to anyone in possession 3 times or more

**c) Cannabis is a class B drug under the UK Misuse of Drugs Act 1971**

d) Possession of cannabis will incur a penalty of 3 months imprisonment with £2 000 fine

**803. A patient in your care is on regular oral morphine sulphate. As a qualified nurse, what legal checks do you need to carry out every time you administer it, which are in addition to those you would check for every other drug you administer?**

a) Check to see if the patient has become tolerant to the medication so it is no longer effective as analgesia.

b) Check to see whether the patient has become addicted.

**c) Check the stock of oral morphine sulphate in the CD cupboard with another registered nurse and record this in the control drug book; together, check the correct prescription and the identity of the patient.**

d) Check the stock of oral morphine sulphate in the CD cupboard with another registered nurse and record this in the control drug book; then ask the patient to prove their identity to you

**804. Which of the following drugs will require 2 nurses to check during preparation and administration?**

- a) oral antibiotics
- b) glycerine suppositories
- c) **morphine tablet**
- d) oxygen

805. **A patient was on morphine at hospital. On discharge doctor prescribes fentanyl patches. At home patient should be observed for which sign of opiate toxicity?**

- a) **Shallow, slow respiration, drowsiness, difficulty to walk, speak and think**
- b) Rapid, shallow respiration, drowsiness, difficulty to walk, speak and think
- c) Rapid wheezy respiration, drowsiness, difficulty to walk, speak and think

806. **Prothrombin time is essential during anticoagulation therapy. In oral anticoagulation therapy which test is essential?**

- a) Activated Thromboplastin Time - The partial thromboplastin time (PTT) test is a blood test that is done to investigate bleeding disorders and to monitor patients taking an anticlotting drug (heparin).
- b) **International Normalized Ratio - The Prothrombin time (PT) test, standardised as the INR test is most often used to check how well anticoagulant tablets such as warfarin and phenindione are working**

807. **Precise indicator of anticoagulation status when on oral anticoagulants**

- A) Ptt
- B) aPTT
- C) ct
- D) INR**

808. **You are the named nurse of Mr Corbyn who has just undergone an abdominal surgery 4 hours ago. You have administered his regular analgesia 2 hours ago and he is still complaining of pain. Your most immediate, most appropriate nursing action?**

- a) call the doctor
- b) assist patient in a comfortable position**
- c) **give another dose**
- d) look for a heating pad

809. **Mild pain after surgery and pain is reduced by taking which medicine**

- a) paracetamol**
- b) ibuprofen
- c) paracetamol with codeine
- d) paracetamol with morphine

810. John is also prescribed some medications for his Gout. Which of the following health teaching will you advise him to do?
- a) Increase fluid intake 2 - 3 liters per day
  - b) Have enough sunshine
  - c) Avoid paracetamol (first line analgesic)
  - d) avoid dairy products
811. A patient doesn't take a tablet which is prescribed by a doc. Nurse should
- a) Inform the incident to senior nurse and ward in charge
  - b) Inform pharmacist
  - c) Do not inform anybody...routinely chart
812. Oral corticosteroids side effect
- a) mood variation
  - b) edema
813. On which step of the WHO analgesic ladder would you place tramadol and codeine?
- a) Step 1: Non Opioid Drugs
  - b) Step 2: Opioids for Mild to Moderate Pain
  - c) Step 3: Opioids for Moderate to Severe Pain
  - d) Herbal medicine
814. What could be the reason why you instruct your patient to retain on its original container and discard nitroglycerine meds after 8 weeks?
- A) removing from its darkened container exposes the medicine to the light and its potency will decrease after 8 weeks
  - B) it will have a greater concentration after 8 weeks
815. A sexually active female , who has been taking oral contraceptives develops diarrhoea. Best advice
- a. Advise her to refrain from sex till next periods
  - b. Advice to switch to other measures like condoms, as diarrhoea may reduce the effect of oral contraceptives
816. A patient is prescribed metformin 1000mg twice a day for his diabetes. While talking with the patient he states "I never eat breakfast so I take a ½ tablet at lunch and a whole tablet at supper because I don't want my blood sugar to drop." As his primary care nurse you:

- A. Tell him he has made a good decision and to continue
- B. Tell him to take a whole tablet with lunch and with supper
- C. Tell him to skip the morning dose and just take the dose at supper
- D. Tell him to take one tablet in the morning and one tablet in the evening as ordered

**817. A Ibuprofen 200mg tablet has been prescribed. You only have a 400mg coated ibuprofen tablet. What should you do?**

- A. Give half of the tablet
- B. crush the tablet and give half of the amount
- C. order the different dose of tablet from pharmacy
- D. omit

**818. A patient develops shortness breath after administering 3<sup>rd</sup> dose of penicillin. The patient is unwell. Ur response**

- a) Call for help, ensure anaphylaxis pack is available, assess ABC, dnt leave the patient until medical help comes
- b) Assesss ABC, make patient lie flat, reassure and continue observing

**819. An antihypertensive medication has been prescribed for a client with HTN. The client tells the clinic nurse that they would like to take an herbal substance to help lower their BP. The nurse should take which action?**

- a) Tell the client that herbal substances are not safe & should never be used
- b) Teach the client how to take their BP so that it can be monitored closely
- c) Encourage the client to discuss the use of an herbal substance with the health care provider

**820. Dennis was admitted because of acute asthma attack. Later on in your shift, he complained of abdominal pain and vomited. He asked for pain relief. Which of the following prescribed analgesia will you give him?**

- a) Fentanyl buccal patch
- b) Ibuprofen enteric coated capsules
- c) Paracetamol suppositories
- d) Oromorphine

**821. What is the best position in applying eye medications?**

- a) Sitting position with head tilt to the right
- b) Sitting position with head tilt backwards
- c) Prone position with head tilt to the left

**822. How should eye drops be administered?**

- A. \*Pulling on the lower eyelid and administering the eye drops
- B. Pulling on the upper eyelid and administering the eye drops

- C. Tip the patients head back and administer the eye drops into the cornea
- D. Tip the patients head to the side and administer the eye drops into the nasolacrimal system

823. What fluid should ideally be used when irrigating eyes?

- A. sterile 0.9% sodium chloride
- B. Sterile water
- C. Chloramphenicol drops
- D. tap water

732. Select which is **not** a proper way of Administering Eye Drops?

- a) Administer the prescribed number of drops, holding the eye dropper 1-2 cm above the eye. If the patient links or closes their eye, repeat the procedure
- b) ask the patient to close their eyes and keep them closed for 1-2 minutes
- c) If administering both drops and ointment, administer ointment first
- d) Ask the patient to sit back with neck slightly hyper extended or lie down

824. All but one are signs of opioid toxicity:

- A. CNS depression (coma)
- B. Pupillary miosis
- C. Respiratory depression (cyanosis)
- D. Tachycardia

825. Jim is to receive his eyedrops after his cataract operation. What is the best position for Jim to assume when instilling the eyedrops?

- a) sitting position, head tilted backwards
- b) supine position for comfort
- c) standing position to facilitate drainage
- d) recovery position

826. What is not a good route for IM injection?

- A. upper arm
- B. stomach
- C. thigh
- D. buttocks



827. Who is responsible in disposing sharps?

- a) Registered nurse
- b) Nurse assistant
- c) Whoever used the sharps
- d) Whoever collects the garbage

**828. What steps would you take if you had sustained a needlestick injury?**

- a) Ask for advice from the emergency department, report to occupational health and fill in an incident form.
- b) Gently make the wound bleed, place under running water and wash thoroughly with soap and water. Complete an incident form and inform your manager. Co-operate with any action to test yourself or the patient for infection with a bloodborne virus but do not obtain blood or consent for testing from the patient yourself; this should be done by someone not involved in the incident.
- c) Take blood from patient and self for Hep B screening and take samples and form to Bacteriology. Call your union representative for support. Make an appointment with your GP for a sickness certificate to take time off until the wound site has healed so you don't contaminate any other patients.  
Wash the wound with soap and water. Cover any wound with a waterproof dressing to prevent entry of any other foreign material

**829. You were administering a pre-operative medication to a patient via IM route. Suddenly, you developed a needle-stick injury. Which of the following interventions will not be appropriate for you to do?**

- A. Prevent the wound to bleed
- B. Wash the wound using running water and plenty of soap
- C. Do not suck the wound
- D. Dry the wound and cover it with a waterproof plaster or dressing

**830. UK policy for needle prick injury includes all but one:**

- A. Encourage the wound to bleed
- B. Suck the wound
- C. Wash the wound using running water and plenty of soap
- D. Don't scrub the wound while washing it

**831. One of your patient has challenged your recent practice of administering a subcutaneous low-molecular weight heparin (LMWH) without disinfecting the injection site. The guidelines for nursing procedures do not recommend this method. Which of the following response will support your action?**

- A. "We were taught during our training not to do so as it is not based on evidence."
- B. "Our guidelines, which are based on current evidence, recommends a non-disinfection method of subcutaneous injection."
- C. "I am glad you called my attention. I will disinfect your injection site next time to ensure your safety and peace of mind."
- D. "Disinfecting the site for subcutaneous injection is a thing of the past. We are in an evidence-based practice now."

**832. IV injection need to be reconsidered when,?**

- A. Medicine is available in tab form

B. Poor alimentary absorption

C. Drug interaction due to GI secretions

833. Which is the most dangerous site for intramuscular injection?

- a) ventrogluteal
- b) deltoid
- c) rectus femoris
- d) dorsogluteal

834. Which is the best site for giving IM injection on buttocks

- a) Upper outer quadrant
- b) Upper inner quadrant
- c) Lower outer quadrant
- d) Lower inner quadrant

835. When administering injection in the buttocks, it should be given:

- a) right upper quadrant
- b) left upper quadrant
- c) right lower quadrant
- d) left lower quadrant

836. What is not a good route for IM injection?

- a) upper arm
- b) stomach
- c) thigh
- d) buttocks

837. The degree of injection when giving subcutaneous insulin injection on a site where you can grasp 1 inch of tissue?

- A) 45degrees
- B) 40degrees
- C) 25degrees

838. Which is the first drug to be used in cardiac arrest of any aetiology?

- e) Adrenaline
- f) Amiodarone
- g) Atropine
- h) Calcium chloride

839. Why would the intravenous route be used for the administration of medications?

- i) It is a useful form of medication for patients who refuse to take tablets because they don't want to comply with treatment
- j) It is cost effective because there is less waste as patients forget to take oral medication
- k) The intravenous route reduces the risk of infection because the drugs are made in a sterile environment & kept in aseptic conditions
- l) **The intravenous route provides an immediate therapeutic effect & gives better control of the rate of administration as a more precise dose can be calculated so treatment can be more reliable**
- m) more precise dose can be calculated so treatment can be more reliable

**840. What is the best nursing action for this insertion site. You have observed an IV catheter insertion site w/ erythema, swelling, pain and warm.**

- a) start antibiotics
- b) **re-site cannula**
- c) call doctor
- d) elevate

**841. What are the key nursing observations needed for a patient receiving opioids frequently?**

- A. **Respiratory rate, bowel movement record and pain assessment and score.**
- B. Checking the patient is not addicted by looking at their blood pressure.
- C. Lung function tests, oxygen saturations and addiction levels.
- D. Daily completion of a Bristol stool chart, urinalysis, and a record of the frequency with which the patient reports breakthrough pain.

**842. What is the best way to avoid a haematoma forming when undertaking venepuncture?**

- a) Tap the vein hard which will 'get the vein up', especially if the patient has fragile veins. This will avoid bruising afterwards.
- b) It is unavoidable and an acceptable consequence of the procedure. This should be explained and documented in the patient's notes.
- c) **Choosing a soft, bouncy vein that refills when depressed and is easily detected, and advising the patient to keep their arm straight whilst firm pressure is applied.**
- d) Apply pressure to the vein early before the needle is removed, then get the patient to bend the arm at a right angle whilst applying firm pressure

**843. A nurse is not trained to do the procedure of IV cannulation, still she tries to do the procedure. You are the colleague of this nurse. What will be your action?**

- a) You should tell that nurse to not to do this again
- b) You should report the incident to someone in authority
- c) You must threaten the nurse, that you will report this to the authority
- d) You should ignore her act

844. You have just administered an antibiotic drip to you patient. After few minutes, your patient becomes breathless and wheezy and looks unwell. What is your best action on this situation?

- a) Stop the infusion, call for help, anaphylactic kit in reach, monitor closely
- b) continue the infusion and observe further
- c) check the vital signs of the patient and call the doctor
- d) stop the infusion and prepare a new set of drip

845. While giving an IV infusion your patient develops speed shock. What is not a sign and symptom of this?

- A. Circulatory collapse
- B. Peripheral oedema
- C. Facial flushing
- D. Headache

846. What is the most common complication of venepuncture?

- a) Nerve injury
- b) Arterial puncture
- c) Haematoma
- d) Fainting

847. A patient with burns is given anesthesia using 50%oxygen and 50%nitrous oxide to reduce pain during dressing. how long this gas is to be inhaled to be more effective?

- A) 30 sec
- B) 60sec
- C) 1-2min
- D) 3-5min

848. You have observed an IV catheter insertion site w/ erythema, swelling, pain and warm? What VIP score would you document on his notes?

- a) 5
- b) 2
- c) 3
- d) 4

849. After iv dose patient develops, rashes, itching, flushed skin

- A) septicemia
- B) adverse reaction**

850. **Hypokalemia can occur in which situation?**

- A) Addison's disease
- B) When use spironolactone
- C) When use furosemide**

851. **Dehydration is of particular concern in ill health. If a patient is receiving intravenous (IV) fluid replacement and is having their fluid balance recorded, which of the following statements is true of someone said to be in a positive fluid balance?**

- A) The fluid output has exceeded the input.
- c) The doctor may consider increasing the IV drip rate.
- d) The fluid balance chart can be stopped as positive in this instance means good.
- e) The fluid input has exceeded the output.**

852. **A patient is on Inj. Fentanyl skin patch common side effect of the fentanyl overdose is**

- a) Fast and deep breathing, dizziness, sleepiness
- b) Slow and shallow breathing, dizziness, sleepiness**
- c) Noisy and shallow breathing, dizziness, sleepiness
- d) Wheeze and shallow breathing, dizziness, sleepiness

853. **As a registered nurse, you are expected to calculate fluid volume balance of a patient whose input is 2437 ml and output is 750 ml**

- a) 1887 (Negative Balance)
- b) 1197 (Negative Balance)
- c) 1887 (Positive Balance)**
- d) 1197 (Positive Balance)

854. **What does the term 'breakthrough pain' mean, and what type of prescription would you expect for it?**

- a) A patient who has adequately controlled pain relief with short lived exacerbation of pain, with a prescription that has no regular time of administration of analgesia.**
- b) Pain on movement which is short lived, with a q.d.s. prescription, when necessary.
- c) Pain that is intense, unexpected, in a location that differs from that previously assessed, needing a review before a prescription is written.
- d) A patient who has adequately controlled pain relief with short lived exacerbation of pain, with a prescription that has 4 hourly frequency of analgesia if necessary

855. A patient is agitated and is unable to settle. She is also finding it difficult to sleep, reporting that she is in pain. What would you do at this point?

- a) Ask her to score her pain, describe its intensity, duration, the site, any relieving measures and what makes it worse, looking for non verbal clues, so you can determine the appropriate method of pain management.
- b) Give her some sedatives so she goes to sleep.
- c) Calculate a pain score, suggest that she takes deep breaths, reposition her pillows, return in 5 minutes to gain a comparative pain score.
- d) Give her any analgesia she is due. If she hasn't any, contact the doctor to get some prescribed. Also give her a warm milky drink and reposition her pillows. Document your action.

856. How should we transport controlled drugs? Select which does not apply:

- A. Controlled drugs should be transferred in a secure, locked or sealed, tamper-evident container.
- B. A person collecting controlled drugs should be aware of safe storage and security and the importance of handing over to an authorized person to obtain a signature.
- C. Have valid ID badge
- D. None of the above

857. Dennis was admitted because of acute asthma attack. later on in your shift he complained of abdominal pain and vomited. He asked for pain relief. Which of the following prescribed analgesia will you give him?

- a) Fentanyl buccal patch
- b) Ibuprofen enteric coated capsule
- c) Paracetamol suppositories
- d) Oromorphine

858. What do you mean by MRSA?

- a) methicillin-resistant staphylococcus aureus
- b) multiple resistant staphylococcus antibiotic

859. Patient is given penicillin. After 12 hrs he develops itching, rash and shortness of breath. what could be the reason?

- n) Speed shock
- o) Allergic reaction

860. Which color card is used to report adverse drug reaction?

- a) Green Card

- b) **Yellow Card**
- c) White Card
- d) Blue Card

861. Which drug can be given via NG tube?

- A) Modified release hypertensive drugs
- B) **Crushing the tablets**
- C) **Lactulose syrup**
- D) Insulin

862. 500mg of Amoxicillin is prescribed to a patient three times a day, 250mg tablets are available. How many tablets for single dose?

- a) 6
- b) 4
- c) **2**
- d) 8

863. The doctor prescribes a dose of 9 mg of an anticoagulant for a patient being treated for thrombosis. The drug is being supplied in 3mg tablets. How many tablets should you administer?

- a) **3 tablets**
- b) 1.5 tablets
- c) 6 tablets

864. The doctor prescribes a dose of 9 mg of an anticoagulant for a patient being treated for thrombosis. The drug is being supplied in 3mg tablets. How many tablets should you administer?

- A) **3 tablets**
- B) 1.5 tablets
- C) 6 tablets

865. 2.5 mg tablet. 5 mg to be given. How many tablets to be given?

- a) 2

866. 1000 mg dose to be given thrice a day. 250 mg tabs available. No. of tabs in single dose?

4

867. A drug 150g is prescribed it is available as 5 g tablets. how many tablets need to be administered?

**30 tablets**

868. Paracetamol 1gm is ordered. It is available as 500mg. How many tablets need to be administered?

2 tablets

869. You need to give 40mg tablet. available is 2.5mg tablets. How much tablets will you give?

16 tablets

870. A dose of 100 ml of injection Metronidazole is to be infused over half an hour. How much amount of the medicine will be given in an hour?

- a) 50 ml
- b) 150 ml
- c) 200 ml
- d) 300 ml

871. The doctor prescribes 25mg of a drug to be given by injection. It is a drug dispensed in a solution of strength 50mg/ml. How many ml should you administer?

- 2ml
- 1.5 ml
- 0.5 ml – Dose Prescribed: Dose /ml -  $25:50=0.5$

872. Mr Bond will require 10 mgs of oromorph. The stock comes in 5 mg/2ml. How much will you draw up from the bottle?

- a) 4 ml
- b) 10 ml
- c) 6 ml
- d) 8 ml

873. A doctor prescribes an injection of 200 micrograms of drug. The stock bottle contains 1mg/ml. How many ml will you administer?

- a) 20ml
- b) 2 ml
- c) 0.2 ml

874. An infusion of 24 mg of Inj. Furosemide is ordered for 12 hrs. How much dose is infused in an hour?

- a) 4 mg/hr
- b) 2 mg/hr
- c) 3 mg/hr
- d) 1 mg/hr

875. A patient with burns is given anesthesia using 50% oxygen and 50% nitrous oxide to reduce pain during dressing . how long this gas is to be inhaled to be more effective?

- 30 sec
- 60sec
- 1-2min
- 3-5min

876. A doctor prescribes an injection of 200 micrograms of drug. The stock bottle contains 1mg/ml. How many ml will you administer? *Bear in mind: The 2 dose values must be in the same unit 1mg=1000mcg , 200mcg=0.2mg then dose prescribed:dose/ml – 0.2:1=0.2*

- A) 20ml
- B) 2ml
- C) 0.2ml

877. A drug 8.25mg is ordered, it is available as 2.75mg. Calculate the dose.

3 tablets

NB- fluid gvn sets =20 drops per minute

Blood gvn set=15 drops per minute

Burret gvn set=60dr per minute

878. A solution contains 12.5 g of glucose in 0.25 l; what is the percentage concentration (%) of this solution?

$$\frac{1250\text{mg (12.5g)}}{250\text{ml (0.25 L)}}$$

$$= 5$$

- a) 5%
- b) 10%
- c) 25%

879. A litre bag of 5% Glucose is prescribed over 4 hours. If a standard giving set is used, at what rate should the drip be set?

$$\frac{1000}{4} \times \frac{20}{60}$$

$$= \frac{250}{1} \times \frac{1}{3}$$

$$= 83$$

- a) 83
- b) 60
- c) 24

880. Amitriptyline tablets are available in strengths of 10mg, 25mg, 50mg and 100mg. What combinations of whole tablets should be used for an 85mg dose?



$$25\text{mg} \times 3 + 10\text{mg} = 85\text{mg}$$

881. 900mg of penicillin is to be given orally. Stock mixture contains 250mg/5ml. Calculate the volume of mixture to be given.

$$18 \text{ mls}$$

882. An injection of fentanyl 225micrograms is prescribed. Stock on hand is 500micrograms in 2ml. What volume of stock should be given?

$$1 \text{ microgram}$$

883. Over a period of 9 hours a patient is to receive half a litre of dextrose 4% in  $\frac{1}{5}$  normal saline via a volumetric infusion pump. At what flow rate should the pump be set?

$$500 \div 9 = 55.5\text{ml per hour}$$

884. Which of the following is considered a medication?

- a) Whole blood
- b) Albumin
- c) Blood Clotting Factors
- d) Antibodies

885. Over a period of 9 hours a patient is to receive half a liter of dextrose 4 % in 1/5 normal saline via a volumetric infusion pump. At what flow rate should the pump be set?

$$\frac{\text{Volume required (ml)}}{\text{Hours}} \times \frac{\text{drop factor}}{60}$$

$$\frac{500\text{ml}}{9} \times \frac{20}{60}$$

$$500 \times 1$$

$$27$$

$$= 18.5 \text{ ml}$$

$$= 19\text{ml}$$

886. A patient is prescribed 120 ml of Hartmann's solution to be given over 5 hours. The microdrip delivers 60 drops/ml. calculate the required drip rate in drops/min

24 drops per minute

$$\frac{\text{Volume required (ml)}}{\text{Hours}} \times \frac{\text{drop factor}}{60}$$

$$\frac{120\text{mls}}{5} \times \frac{60}{60}$$

$$= 24 \text{ drops per minute}$$

887. At 22H00 hours on Thursday, 1 Liter of Saline is set to run at 80ml/hr. When will the infusion be finished:

$$\frac{\text{Volume to be infused (ml)}}{\text{rate (ml per hour)}}$$

$$\frac{1000\text{ml}}{80\text{ml}}$$

$$= 12\text{H}30 \text{ mintes}$$

Answer: 10:30 am

888. A Patient is to be given co-amoxiclav. The Recommended dosage is 20mg/kg/day, 3 doses per day. Calculate the size of a single dose if the patients weight is 24kg

$$\text{Dosage required} = \text{prescription} \times \text{body weight}$$

$$20\text{mg} \times 24\text{kg} = 480\text{mg}$$

$$480/3 = 160\text{mg}$$

889. **450 mg of asprin is required. Stock on hand is 300mg tablets. How many tablets should be given?**

Prescription for the patient  
Stock strength available

= tablets

$$\frac{450\text{mg}}{300\text{mg}}$$

1½ tablets

890. **A solution contains paractamol 120mg/5ml. How many milligrams of paracetamol are in 40 ml of the solution.**

$$120\text{mg} \times 8$$

Because 5 ml = 120 and in 40ml there are 5mlx8 (40/5)

$$= 960 \text{ mg}$$

891. **A patient is prescribed phenobarbitone 140mg. stock ampoules contain 200mg/ml. what volume must be withdrawn for injection?**

Prescription for the patient X stock volume (ml)  
Stock strength available

= volume given (ml)

$$\frac{140\text{mg} \times 1\text{ml}}{200\text{mg}}$$

$$= 0,7 \text{ mls}$$

892. **800ml of fluid is to be given IV. The fluid is running at 70ml/hr for the first 5 hours than the rate is reduced to 60ml/hr. Calculate the total time taken to give 800ml.**

$$70\text{ml} \times 5 = 350\text{mls}$$

$$450/60\text{ml} = 7\text{hours and } 30 \text{ minutes}$$

Total infusion time is: 7 hours 30 minutes + 5 hours = 12 hours 30 minutes

893. One liter of Hartmann's solution is to be given over 12 hours. Calculate the flow rate of a volumetric infusion pump

$$\frac{\text{Volume required for the patient (ml)}}{\text{Time (hours)}}$$

$$\frac{1000\text{ml}}{12}$$

$$83,3 \text{ ml}$$

$$= 83 \text{ ml}$$

894. 400mg of penicillin is to be given IV. One hand is penicillin 600mg in 2 ml. What volumes should be drawn up?

$$\frac{400\text{ml} \times 2\text{ml}}{600\text{mg}}$$

$$= \frac{800}{600}$$

$$= 1,3 \text{ ml}$$

895. A patient is prescribed benzylpenicillin 1200mg IV. Stock ampouls contain 1g in 5ml. is the volume to be drawn up for injection equal to 5ml, less than 5 ml or more than 5ml?

$$\frac{1200\text{mg} \times 5\text{mls}}{1000}$$

$$\frac{6000\text{mg}}{1000\text{mg}}$$

$$= 6\text{mls} \text{ this more than 5mls}$$

896. A vial of amoxilling 500mg is reconstituted with WFI to give a concentration of 200mg/ml. Calculate the volume of this solution to be drawn up for injection if the preparation is for 120mg.

$$\frac{120\text{mg}}{200\text{mg}}$$

$$0.6 \text{ mg}$$

897. 700ml of saline solution is to be given over 8 hours. The IV set delivers 20 drops/ml. What is the required drip rate?

$$\frac{\text{Volume required (ml)}}{\text{Hours}} \times \frac{\text{drop factor}}{60}$$

$$\frac{700\text{ml} \times 20}{8 \times 60}$$

$$\frac{87.5 \times 1}{1 \times 3}$$

$$= 29,1$$

$$= 29 \text{ drops per minute}$$

898. **One gram of dextrose provide 16kj of energy. How many kilojouls does a patient receive form an infusion of half a litre of dextrose?**

$$1\text{g (1 000ml)} = 16\text{kg}$$

$$500\text{ml (}\frac{1}{2}\text{ a liter)} = 16/2 = 8\text{kj}$$

899. **A patient is to be given amoxillin 175mg. What volume of solution should be drawn up for the injection if the consentration after dilution with water for injection is 300mg/ml**

$$\frac{\text{Prescription for the patient} \times \text{stock volume (ml)}}{\text{Stock strength available}}$$

$$= \text{volume given (ml)}$$

$$\frac{175\text{mg} \times 1}{300\text{mg}}$$

$$= 0.58 \text{ ml}$$

$$= 0.6\text{ml}$$

900. A post-operative patient is to receive a PCA infusion of fetanyl 350 micrograms in 35 ml of normal saline via a syringe pump. The PCA is set to give a bolus dose of 1 ml each time the button is pressed

- a) What is the concentration of the fentanyl in saline solution?

$$\frac{350\text{mcg}}{35\text{ml}}$$

$$= \frac{0,35\text{mg}}{35}$$

$$= 0.01 \text{ mg}$$

- b) How much fentanyl is in each bolus dose

Amount of drug per bolus = concentration x volume

$$0.01\text{mg} \times 1\text{ml} = 0.1\text{mg}$$

- c) If the patient has 4 bolus doses between 11:00 and 12:00 hours on a Friday, how much fentanyl has the patient received in that hour?

$$4 \text{ bolus} \times 0.01\text{mg} = 0.04\text{mg}$$

901. **Pharmacokinetics can be described as:**

- a) The study of the effects of drugs on the function of living systems
- b) **The absorption, distribution, metabolism and excretion of drugs within the body: what the body does to drug**
- c) The study of mechanism of the action of drugs and other biochemical physiological effects: 'what the drug does to the body'
- d) All of the above

902. **The medicine and Healthcare Products Regulatory Agency (MHRA) is responsible for what?**

- a) Licensing medicinal products
- b) Regulating the manufacture, distribution and importation of medicines
- c) Regulating which medicines require a prescription and which can be available without a prescription and under what circumstances
- d) **All of the above**

903. **Medication errors account for around a quarter of the incidents that threaten patient safety. In a study published in 2000 it was found that 10% of all patients admitted to hospital suffer an adverse event (incident). How much of these incidents were preventable?**

- a) 20%
- b) 30%
- c) **50%**
- d) 60%

904. **You are about to administer Morphine Sulphate to a paediatric patient. The information written on the controlled drug book was not clearly written – 15mg or 0.15 mg. What will you do first?**

- a) Not administer the drug, and wait for the General Practitioner to do his rounds
- b) Administer 0.15 mg, because 15 mg is quite a big dose for a paediatric patient
- c) **Double check the medication label and the information on the controlled drug book; ring the chemist to verify the dosage**
- d) Ask a senior staff to read the medication label for you

905. After having done your medication round, you have realised that your patient has experienced the adverse effect of the drug. What will be your initial intervention?
- a) You must do the physical observations and notify the General practitioner
  - b) You must ring the General Practitioner and request for a home visit
  - c) You must administer medication from the Homely Remedy Pod after having spoken to the General Practitioner.
  - d) You must observe your patient until the General Practitioner arrives at your nursing home
906. Your patient has been prescribed Tramadol 50 mgs tablet for pain relief. Upon receipt of the tablets from the pharmacist you will:
- A. Record this in the controlled drug register book with the pharmacist witnessing
  - B. Put it in the patient's medicine pod
  - C. Store it in ward medicine cupboard
  - D. Ask the pharmacist to give it to the patient
907. The nurse is admitting a client, on initial assessment the nurse tries to inquire the patient if he has been taking alternative therapies and OTC drugs but the client becomes angry and refuses to answer saying the nurse is doing so because he belongs to an ethnic minority group, what is the nurse's best response?
- a) The nurse will stop asking questions as it is upsetting to the patient
  - b) Wait and give some time for the client to get adjusted to modern ways of hospitalisation
  - c) The nurse will politely explain to the patient about alternative therapies such as St. Johns Wort which interact with drugs
  - d) The nurse will assign another nurse to ask questions
908. Independent and supplementary nurse and midwife are those who are?
- A. nurse and midwife student who cleared medication administration exam
  - B. nurses and midwives educated in appropriate medication prescription for certain pharmaceuticals
  - C. registrants completed a programme to prescribe under community nurse practitioner's drug formulary
  - D. nurses and midwives whose name is entered in the register
909. A patient needs weighing, as he is due a drug that is calculated on bodyweight. He experiences a lot of pain on movement so is reluctant to move, particularly stand up. What would you do?
- A. Document clearly in the patient's notes that a weight cannot be obtained
  - B. Offer the patient pain relief and either use bed scales or a hoist with scales built in
  - C. Discuss the case with your colleagues and agree to guess his body weight until he agrees to stand and use the chair scales

D. Omit the drugs as it is not safe to give it without this information; inform the doctor and document your actions

**910. A nurse is caring for clients in the mental health clinic. A woman comes to the clinic complaining of insomnia and anorexia. The patient tearfully tells the nurse that she was laid off from a job that she had held for 15 years. Which of the following responses, if made by the nurse, is MOST appropriate?**

- A. "Did your company give you a severance package?"
- B. "Focus on the fact that you have a healthy, happy family."
- C. "Losing a job is common nowadays."
- D. "Tell me what happened."

**911. On physical examination of a 16 year old female patient, you notice partial erosion of her tooth enamel and callus formation on the posterior aspect of the knuckles of her hand. This is indicative of:**

- a) Self-induced vomiting and she likely has bulimia nervosa
- b) A genetic disorder and her siblings should also be tested
- c) Self-mutilation and correlates with anxiety
- d) A connective tissue disorder and she should be referred to dermatology

**912. An adolescent male being treated for depression arrives with his family at the Adolescent Day Treatment Centre for an initial therapy meeting with the staff. The nurse explains that one of the goals of the family meeting is to encourage the adolescent to:**

- a) Trust the nurse who will solve his problem
- b) Learn to live with anxiety and tension
- c) Accept responsibility for his actions and choices
- d) Use the members of the therapeutic milieu to solve his problems

**913. A suicidal Patient is admitted to psychiatric facility for 3 days when suddenly he is showing signs of cheerfulness and motivation. The nurse should see this as:**

- a) That treatment and medication is working
- b) She has made new friends
- c) she has finalized suicide plan

**914. When caring for clients with psychiatric diagnoses, the nurse recalls that the purpose of psychiatric diagnoses or psychiatric labelling to:**

- a) Identify those individuals in need of more specialized care.
- b) Identify those individuals who are at risk for harming others
- c) Define the nursing care for individuals with similar diagnoses
- d) Enable the client's treatment team to plan appropriate and comprehensive care

915. Which of the following situations on a psychiatric unit are an example of trusting patient nurse relationship?

- a) The patient tells the nurse he feels suicidal
- b) The nurse offers to contact the doctor if the patient has a headache
- c) The nurse gives the patient his daily medications right on schedule
- d) The nurse enforces rules strictly on the unit

916. Which of the following situations on a psychiatric unit are an example of a trusting a patient-nurse relationship?

- a) The patient tells the nurse that he feels suicidal
- b) The nurse offers to contact the doctor if the patient has a headache
- c) The nurse gives the patient his daily medication right on schedule
- d) The nurse enforce rules strictly on the unit

917. After two weeks of receiving lithium therapy, a patient in the psychiatric unit becomes depressed. Which of the following evaluations of the patient's behavior by the nurse would be MOST accurate?

- A) The treatment plan is not effective; the patient requires a larger dose of lithium.
- B) This is a normal response to lithium therapy; the patient should continue with the current treatment plan.
- C) This is a normal response to lithium therapy; the patient should be monitored for suicidal behavior.

918. A patient with a history of schizophrenia is admitted to the acute psychiatric care unit. He mutters to himself as the nurse attempts to take a history and yells. "I don't want to answer any more questions! There are too many voices in this room!" Which of the following assessment questions should the nurse ask NEXT?

- a) Are the voices telling you to do things?
- b) Do you feel as though you want to harm yourself or anyone else?
- c) Who else is talking in this room? It's just you and me
- d) I don't hear any other voices



919. The wife of a client with PTSD (post-traumatic stress disorder) communicate to the nurse that she is having trouble dealing with her husband's condition at home. Which of the following suggestions made by the nurse is CORRECT?

- a) Do not touch or speak to your husband during an active flashback. Wait until it is finished to give him support."
- b) Discourage your husband from exercising, as this will worsen his condition
- c) Encourage your husband to avoid regular contact with outside family members
- d) Keep your cupboards free of high-sugar and high-fat foods

920. On a psychiatric unit, the preferred milieu environment is BEST describe as:
- a) Fostering a therapeutic social, cultural, and physical environment.
  - b) Providing an environment that will support the patient in his or her therapeutic needs
  - c) Fostering a sense of well-being and independence in the patient
  - d) Providing an environment that is safe for the patient to express feelings
921. A new mother is admitted to the acute psychiatric unit with severe postpartum depression. She is tearful and states, "I don't know why this happened to me! I was excited for my baby to come, but now I don't know!" Which of the following responses by the nurse is MOST therapeutic?
- a) Having a new baby is stressful, and the tiredness and different hormones levels don't help. It happens to many new mothers and is very treatable.
  - b) Maybe you weren't ready for a child after all
  - c) What happened once you brought the baby home? Did you feel nervous?
  - d) Has your husband been helping you with the housework at all?
922. A 17-year old patient who was involved in an orthopaedic accident is observed not eating the meals that she previously ordered and refuses to take a bath even if she is already in recovery stage. As a nurse what do you think is the best explanation for her reaction to the accident that happened to her?
- A) Supression
  - B) Undoing
  - C) Regression
  - D) Repression
923. After the suicide of her best friend Marry feels a sense of guilt, shame and anger because she had not answered the phone when her friend called shortly before her death. Which of the following statements is the most accurate when talking about Mary's feelings?
- a) Marry's feelings are normal and are a form of perceived loss
  - b) Marry's feelings are normal and are a form of situational loss.
  - c) Marry's feelings are not normal and are a form of situational loss.
  - d) Marry's feelings are not normal and are a form of physical loss
924. What is an indication that a suicidal patient has an impending suicide plan:
- a) She/he is cheerful and seems to have a happy disposition
  - b) talk or write about death, dying or suicide
  - c) threaten to hurt or kill themselves
  - d) actively look for ways to kill themselves, such as stockpiling tablets



925. Risk for health issues in a person with mental health issues

- a) Increased than in normal people
- b) Slightly decreased than in normal people
- c) Very low as compared to normal people
- d) Risk is same in people with and without mental illness



926. On a psychiatric unit, the preferred milieu environment is BEST describe as:

- A. Fostering a therapeutic social, cultural, and physical environment.
- B. Providing an environment that will support the patient in his or her therapeutic needs.
- C. Fostering a sense of well-being and independence in the patient.
- D. Providing an environment that is safe for the patient to express feelings.

927. Which of the following cannot be seen in a depressed client?

- a) Inactivity
- b) Sad facial expression
- c) Slow monotonous speech
- d) Increased energy

928. A patient with antisocial personality disorder enters the private meeting room of a nurse unit as a nurse is meeting with a different patient. Which of the following statements by the nurse is BEST?

- a) I'm sorry, but HIPPA says that you can't be her. Do you mind leaving?
- b) You may sit with us as long as you are quiet
- c) I need you to leave us alone
- d) Please leave and I will speak with you when I am done

929. A patient asking for LAMA, the medical team has concern about the mental capacity of the patient, what decision should be made?

- a) Call the police
- b) Let the patient go
- c) Encourage the patient to wait, by telling the need for treatment

930. The nurse restrains a client in a client in a locked room for 3 hours until the client acknowledge wo started a fight in the group room last evening. The nurse's behaviour constitutes;

- a) False imprisonment
- b) Duty of care
- c) Standard of care practice
- d) Contract of care

931. A client has been voluntary admitted to the hospital. The nurse knows that which of the following statements is inconsistent with this type of hospitalization
- a) The client retains all of his or her rights
  - b) The client has a right to leave if not a danger to self or others
  - c) The client can sign a written request for discharge
  - d) The client cannot be released without medical advice.
932. Risk for health issues in a person with mental health issues
- a) Increased than in normal people
  - b) Slightly decreased than in normal people
  - c) Very low as compared to normal people
  - d) Risk is same in people with and without mental illness
933. In reporting contagious diseases, which of the following will need attention at national level:
- a) Measles
  - b) Tuberculosis
  - c) chicken pox
  - d) Swine flu
934. Which one of these notifiable diseases needs to be reported on a national level?
- a) Chicken pox
  - b) Tuberculosis
  - c) Whooping cough
  - d) Influenza
935. When selecting a stoma appliance for a patient who has undergone a formation of a loop colostomy, what factors would you consider?
- a) Patient dexterity, consistency of effluent, type of stoma
  - b) Patient preference, type of stoma, consistency of effluent, state of peristomal skin, dexterity of the patient
  - c) Patient preference, lifestyle, position of stoma, consistency of effluent, state of peristomal skin, patient dexterity, type of stoma
  - d) Cognitive ability, lifestyle, patient dexterity, position of stoma, state of peristomal skin, type of stoma, consistency of effluent, patient preference.
936. If a patient feels a cramping sensation in their abdomen after a colonoscopy, it is advisable that they should do/have which of the following?
- a) Eat and drink as soon as sedation has worn off.

- b) Drink 500 mL of fluid immediately to flush out any gas retained in the abdomen.
  - c) Have half hourly blood pressure performed for 12 hours.
  - d) Be nursed flat and kept in bed for 12 hours.
937. If your patient is unable to reposition themselves, how often should their position be changed?
- a) 1 hourly
  - b) 2 hourly
  - c) 3 hourly
  - d) As often as possible
938. A patient got admitted to hospital with a head injury. Within 15 minutes, GCS was assessed and it was found to be 15. After initial assessment, a nurse should monitor neurological status
- a) Every 15 minutes
  - b) 30 minutes
  - c) 45 minutes
  - d) 60 minutes
939. Glasgow Coma score (GCS) is made up of 3 component parts and these are:
- a) eye opening response/motor response/verbal response
  - b) eye opening response/verbal response/pupil reaction to light
  - c) eye opening response/motor response/pupil reaction to light
  - d) eye opening response/limb power/verbal response
940. Common cause of airway obstruction in an unconscious patient
- a) Oropharyngeal tumor
  - b) Laryngeal cyst
  - c) Obstruction of foreign body
  - d) Tongue falling back
941. A 27- year old adult male is admitted for treatment of Crohn's disease. Which information is most significant when the nurse assesses his nutritional health?
- a) Anthropometric measurements
  - b) Bleeding gums
  - c) Dry skin
  - d) Facial rubor
942. A patient was diagnosed to have Chron's disease. What would the patient be manifesting?

- a) Blood and mucous in the faeces
- b) Fatigue
- c) Loss of appetite
- d) Urgent bowel

943. The following fruits can be eaten by a person with Crohn's Disease except:

- a) Mango
- b) Papaya
- c) Strawberries
- d) Cantaloupe

944. Which of the following statements made by client diagnosed with hepatitis A needs further understanding of the disease.

- a) Washing hands before cooking food
- b) Refraining from sexual intimacy and kissing while symptoms still present
- c) Towels and flannels can be shared with children

945. A client is diagnosed with hepatitis A. which of the following statements made by client indicates understanding of the disease

- a) Sexual intimacy and kissing is not allowed
- b) Does require hospitalization
- c) Transmitted only through blood transfusions
- d) Any planned surgery need to be postponed

946. On assessment of the abdomen of a patient with peritonitis you would expect to find

- a) Rebound tenderness and guarding
- b) Hyperactive, high-pitched bowel sounds and a firm abdomen
- c) A soft abdomen with bowel sounds every 2 to 3 seconds

947. Patients with gastric ulcers typically exhibit the following symptoms:

- a) Epigastric pain worsens before meals, pain awakening patient from sleep and melena
- b) Decreased bowel sounds, rigid abdomen, rebound tenderness, and fever
- c) Boring epigastric pain radiating to back and left shoulder, bluish-grey discoloration of periumbilical area and ascites
- d) Epigastric pains worsens after eating and weight loss

948. A diabetic patient with suspected liver tumor has been prescribed with Trphasic CT scan. Which medication needs to be on hold after the scan?

- a) Furosemide

- b) Metformin
- c) Docusate sodium
- d) Paracetamol

949. According to the royal marsden manual, a staff who observe the removal of chest drainage is considered as?

- a) Official training
- b) Unofficial training
- c) Hours which are not calculated as training hours
- d) It is calculated as prescribed training hours.

950. Which of the following is an indication for intrapleural chest drain insertion?

- a) Pneumothorax
- b) Tuberculosis
- c) Asthma
- d) Malignancy of lungs

951. All but one is an indication for pleural tubing:

- a) Pneumothorax
- b) Abnormal blood clotting screen or low platelet count
- c) Malignant pleural effusion.
- d) Post-operative, for example thoracotomy, cardiac surgery

952. A 45-year old patient was diagnosed to have Piles (Haemorrhoids). During your health education with the patient, you informed him of the risk factors of Piles. You would tell him that it is caused by all of the following except:

- a) Straining when passing stool
- b) being overweight
- c) Lack of fibre in the diet
- d) prolonged walking

953. Correct position for abdominal paracentesis.

- A. Lie the patient supine in bed with the head raised 45–50 cm with a backrest
- B. Sitting upright at 45 to 60
- C. Sitting upright at 60 to 75°
- D. Sitting upright at 75 to 90°

954. Which of the following client should the nurse deal with first

- a) A client who needs to be suctioned
- b) A client who needs her dressing changed

- c) A client who needs to be medicated for incisional pain
- d) A client who is incontinent & needs to be cleaned

955. Which of the following is a potential complication of putting an oropharyngeal airway adjunct:

- A. Retching, vomiting
- B. Bradycardia
- C. Obstruction
- D. Nasal injury

956. A patient suffered from stroke and is unable to read and write. This is called

- a) Dysphasia
- b) Dysphagia
- c) Partial aphasia
- d) Aphasia



957. Patient had CVA, who will assess swallowing capability?

- a) physiotherapy nurse
- b) psychotherapy nurse
- c) speech and language therapist
- d) neurologic nurse

958. A patient suffered from CVA and is now affected with dysphagia. What should not be an intervention to this type of patient?

- a) Place the patient in a sitting position / upright during and after eating.
- b) Water or clear liquids should be given.
- c) Instruct the patient to use a straw to drink liquids.
- d) Review the patient's ability to swallow, and note the extent of facial paralysis.

959. Who should do the assessment in a patient with dysphagia

- A) Neurologic physiotherapist
- B) Speech therapist
- C) Occupation therapist

960. A nurse case manager receives a referral to provide case management services for an adolescent mother who was recently diagnosed with HIV. Which statement indicates that the patient understands her illness?

- a) "I can never have sex again, so I guess I will always be a single parent."
- b) "I will wear gloves when I'm caring for my baby, because I could infect my baby with AIDS."
- c) "My CD4 count is 200 and my T cells are less than 14%. I need to stay at these levels by eating and sleeping well and staying healthy."

- d) "My CD4 count is 800 and my T cells are greater than 14%. I need to stay at these levels by eating and sleeping well and staying healthy."

961. The term gavage indicates

- a) Administration of a liquid feeding into the stomach
- b) Visual examination of the stomach
- c) irrigation of the stomach with solution
- d) A surgical opening through the abdomen to stomach

962. You are caring for a patient with a tracheostomy in situ who requires frequent suctioning. How long should you suction for?

- A. If you preoxygenate the patient, you can insert the catheter for 45 seconds.
- B. Never insert the catheter for longer than 10–15 seconds.
- C. Monitor the patient's oxygen saturations and suction for 30 seconds.
- D. Suction for 50 seconds and send a specimen to the laboratory if the secretions are purulent.

963. What does AVPU mean?

- a) alert verbalization pain unconscious
- b) awake voice pain unconscious
- c) alert voice pain unresponsive
- d) awake verbalization pain unconscious

964. In doing neurological assessment, AVPU means:

- a) awake, voice, pain, unresponsive
- b) alert, voice, pain, unresponsive
- c) awake, verbalises, pain, unresponsive
- d) alert, verbalises, pain, unresponsive

965. In the News observation system, what is AVUP?

- a) A replacement for GCS
- b) An assessment for confusion
- c) Assessment for the level of consciousness

966. You are monitoring a patient in the ICU when suddenly his consciousness drops and the size of one his pupil becomes smaller what should you do?

- a) Refer to neurology team
- b) Continue to monitor patient using GCS and record
- c) Consider this as an emergency, prioritize abc& Call the doctor

967. **Patients with gastrointestinal bleeding may experience acute or chronic blood loss. Your patient is experiencing hematochezia. You recognise this by:**

- a) Red or maroon- coloured stool rectally
- b) Coffee ground emesis
- c) Black, tarry stool
- d) Vomiting of bright red or maroon blood

968. **An assessment of the abdomen of a patient with peritonitis you would expect to find**

- a) Rebound tenderness and guarding
- b) Hyperactive, high-pitched bowel sounds and a firm abdomen
- c) A soft abdomen with bowel sounds every 2 to 3 seconds
- d) Ascites and increased vascular pattern on the skin

969. **A patient was brought to the A&E and manifested several symptoms: loss of intellect and memory; change in personality; loss of balance and co-ordination; slurred speech; vision problems and blindness; and abnormal jerking movements. Upon laboratory tests, the patient got tested positive for prions. Which disease is the patient possibly having?**

- a) Acute Gastroenteritis
- b) Creutzfeldt-Jakob Disease
- c) HIV/AIDS Fatigue
- d) Urgent bowel

970. **Which of the following is NOT a symptom of impacted earwax?**

- a) Dizziness
- b) Dull hearing
- c) Reflux cough
- d) Sneezing

971. **Taking a nursing history prior to the physical examination allows a nurse to establish a rapport with the patient and family. Elements of the history include all of the following except:**

- a) the client's health status
- b) the course of the present illness
- c) social history
- d) Cultural beliefs and practices

972. **Which statement is not true about acute illness?**

- a) A disease with a rapid onset and/or a short course one.
- b) It will eventually resolve without any medical supervision.
- c) It is rapidly progressive and in need of urgent care.
- d) It is prolonged, do not resolve spontaneously, and is rarely captured completely.

973. Patient manifests phlebitis in his IV site, what must a nurse do?

- a) Re-site the cannula
- b) Inform the doctor
- c) Apply warm compress
- d) Discontinue infusion

974. You are caring for a patient with a tracheostomy in situ who requires frequent suctioning. How long should you suction for?

- a) If you preoxygenate the patient, you can insert the catheter for 45 seconds.
- b) Never insert the catheter for longer than 10-15 seconds.
- c) Monitor the patient's oxygen saturations and suction for 30 seconds
- d) Suction for 50 seconds and send a specimen to the laboratory if the secretions are purulent

975. Early ambulation prevents all complications except:

- A. Chest infection and lung collapse
- B. Muscle wasting
- C. Thrombosis
- D. Surgical site infection

976. When a patient is being monitored in the PACU, how frequently should blood pressure, pulse and respiratory rate be recorded?

- a) Every 5 minutes
- b) Every 15 minutes
- c) Once an hour
- d) Continuously

977. Reason for dyspnoea in patients who diagnosed with Glomerulonephritis patients?

- a) Albumin loss increase oncotic pressure causes water retention in cells
- b) Albumin loss causes decrease in oncotic pressure causes water retention causing fluid retention I alveoli
- c) Albumin loss has no effect on oncotic pressure

978. What would be your main objectives in providing stoma education when preparing a patient with a stoma for discharge home?

- a) That the patient can independently manage their stoma, and can get supplies.
- b) That the patient has had their appliance changed regularly, and knows their community stoma nurse.
- c) That the patient knows the community stoma nurse, and has a prescription.
- d) That the patient has a referral to the District Nurses for stoma care.

979. **What would be your main objectives in providing stoma education when preparing a patient with a stoma for discharge home?**

- a) That the patient can independently manage their stoma, and can get supplies
- b) That the patient has had their appliance changed regularly, and knows their community stoma nurse.
- c) That the patient knows the community stoma nurse, and has a prescription.
- d) That the patient has a referral to the District Nurses for stoma care.

980. **What type of diet would you recommend to your patient who has a newly formed stoma?**

- a) Encourage high fibre foods to avoid constipation.
- b) Encourage lots of vegetables and fruit to avoid constipation.
- c) Encourage a varied diet as people can react differently.
- d) Avoid spicy foods because they can cause erratic function.

981. **A patient is admitted to the ward with symptoms of acute diarrhoea. What should your initial management be?**

- a) Assessment, protective isolation, universal precautions
- b) Assessment, source isolation, antibiotic therapy
- c) Assessment, protective isolation, antimotility medication
- d) Assessment, source isolation, universal precautions

982. **You are monitoring a patient in the ICU when suddenly his consciousness drops and the size of one his pupil becomes smaller what should you do?**

- A) Call the doctor
- B) Refer to neurology team
- C) Continue to monitor patient using GCS and record
- D) Consider this as an emergency and prioritize ABC

983. **What is comprehensive nursing assessment?**

- A. It provides the foundation for care that enables individuals to gain greater control over their lives and enhance their health status.
- B. An in-depth assessment of the patient's health status, physical examination, risk factors, psychological and social aspects of the patient's health that usually takes place on admission or transfer to a hospital or healthcare agency.
- C. An assessment of a specific condition, problem, identified risks or assessment of care; for example, continence assessment, nutritional assessment, neurological assessment following a head injury, assessment for day care, outpatient consultation for a specific condition.
- D. It is a continuous assessment of the patient's health status accompanied by monitoring and observation of specific problems identified.

984. **Which statement is not true about acute illness?**

- A. A disease with a rapid onset and/or a short course one.
- B. It will eventually resolve without any medical supervision.



985. **a Patient who has had Parkinson's disease for 7 years has been experiencing aphasia. Which health professional should make a referral to with regards to his aphasia?**

- a) Occupational therapist
- b) Community matron
- c) Psychiatrist
- d) **Speech and language therapist**

986. **Your patient has a bulky oesophageal tumour and is waiting for surgery. When he tries to eat, food gets stuck and gives him heartburn. What is the most likely route that will be chosen to provide him with the nutritional support he needs?**

- A. Nasogastric tube feeding.
- B. Feeding via a percutaneous endoscopic gastrostomy (PEG).
- C. **Feeding via a radiologically inserted gastrostomy (RIG).**
- D. Continue oral food.

987. **A nurse assists the physician is performing liver biopsy. After the biopsy the nurse places the patient in which position?**

- a) Supine
- b) **Prone**
- c) Left-side lying
- d) **Right-side lying**

988. **The first techniques used to examine the abdomen of a client is:**

- a) Palpation
- b) **Auscultation**
- c) Percussion
- d) **Inspection**

989. **When explaining about travellers' diarrhoea which of the following is correct?**

- a) Travellers' diarrhoea is mostly caused by Rotavirus
- b) Antimotility drugs like loperamide is ineffective management
- c) Oral rehydration in adults and children is not useful
- d) **Adsorbents such as kaolin is ineffective and not advised**

853. **Which condition is not a cause of diarrhea?**

- a) Ulcerative colitis
- b) Intestinal obstruction
- c) Hashimotos disease
- d) Food allergy

990. In what instances shouldn't you position a patient in a side-lying position?

- a) If they are pregnant
- b) If they have a spinal fracture
- c) If they have pressure sore
- d) If they have lower limb pain

991. Which among the following is a cause of Hemorrhoids?

- a) High fibre rich diet
- b) Non- processed food
- c) Straining while passing stools
- d) Unsaturated fats in the diet

992. After lumbar laminectomy, which the appropriate method to turn the patient?

- a) Patient holds at the side of the bed, with crossed knees try to turn by own
- b) Head is raised & knees bent, patient tries to make movement
- c) Patient is turned as a unit

993. A client immediately following LP developed deterioration of consciousness, bradycardia, increased systolic BP. What is this normal reaction

- a) client has brain stem herniation
- b) spinal headache

994. While changing tubing and cap change on a patient with central line on right subclavian what should the nurse do to prevent complication

- a) ask patient to breath normally
- b) ask patient to hold the breath and bear down
- c) inhale slowly

995. After finding the patient which statement would be most appropriate for the nurse to document on a datix/incident form?

- a) "The patient climbed over the side rails and fell out of bed."
- b) "The use of restraints would have prevented the fall."
- c) "Upon entering the room, the patient was found lying on the floor."
- d) "The use of a sedative would have helped keep the patient in bed."

996. You are caring for a patient who has had a recent head injury and you have been asked to carry out neurological observations every 15 minutes. You assess and find that his pupils are unequal and one is not reactive to light. You are no longer able to rouse him. What are your actions?

- a) Continue with your neurological assessment, calculate your Glasgow Coma Scale (GCS) and document clearly.
- b) This is a medical emergency. Basic airway, breathing and circulation should be attended to urgently and senior help should be sought.
- c) Refer to the neurology team.
- d) Break down the patient's Glasgow Coma Scale as follows: best verbal response V = XX, best motor response M = XX and eye opening E = XX. Use this when you hand over.

997. A patient in your care knocks their head on the bedside locker when reaching down to pick up something they have dropped. What do you do?

- a) Let the patient's relatives know so that they don't make a complaint & write an incident report for yourself so you remember the details in case there are problems in the future
- b) Help the patient to a safe comfortable position, commence neurological observations & ask the patient's doctor to come & review them, checking the injury isn't serious. when this has taken place , write up what happened & any future care in the nursing notes
- c) Discuss the incident with the nurse in charge , & contact your union representative in case you get into trouble
- d) Help the patient to a safe comfortable position, take a set of observations & report the incident to the nurse in charge who may call a doctor. Complete an incident form. At an appropriate time , discuss the incident with the patient & if they wish , their relatives

998. The nurse can divulge patient's information, only when:

- a) it can pose as a threat to the public and when it is ordered by the court
- b) requested by family members
- c) asked by media personnel for broadcast and publication
- d) required by employer

999. After 2 hours in A and E, Barbara is now ready to be moved to another ward. You went back to tell her about this plan and noticed she was not responding. What is your next action as a priority

- a) Assess for signs of life
- b) Shout for help
- c) Perform CPR
- d) Keep the airway open

1000. A client is brought to the emergency room by the emergency medical services after being hit by car. The name of the client is not known. The client has sustained a severe head injury, multiple fractures and is unconscious. An emergency craniotomy is required, regarding informed consent for the surgical procedure, which of the following is the best action?

- a) Call the police to identify the client and locate the family
- b) Obtain a court order for the surgical procedure
- c) Ask the emergency medical services team to sign the informed consent
- d) Transport the victim to the operating room for surgery

1001. Early signs of phlebitis would include:

- A. slight pain and redness
- B. increased WBC
- C. Pyrexia
- D. swelling

1002. You are monitoring a patient in the ICU when suddenly his consciousness drops and the size of one his pupil becomes smaller what should you do?

- A. Refer to neurology team
- B. Continue to monitor patient using GCS and record
- C. Consider this as an emergency, prioritize abc & Call the doctor

1003. Patient had undergone post lumbar tap and is exhibiting increase HR, decrease BP, and alteration in consciousness and dilated pupils. What is the patient likely experiencing?

- A. Headache
- B. Shock
- C. Brain herniation
- D. Hypotension



1004. Which is not an expected side effect of lumbar tap?

- A. Headache
- B. Back pain
- C. Swelling and bruising
- D. Nausea and vomiting

1005. Which is not an indication for lumbar tap?

- A. For patients with increased ICP
- B. For diagnostic purposes
- C. Introduction of spinal anaesthesia for surgery
- D. Introduction of contrast medium

1006. **It is unsafe for a spinal tap to be undertaken if the patient:**

- A. Has bacterial meningitis
- B. Papilloedema
- C. Intracranial mass is suspected
- D. Site skin infection
- E. **All the above**

1007. **How to position patient for abdominal tap**

- A. Supine
- B. Prone
- C. **Supine with HOB 40-50 degree elevated**
- D. Sitting

1008. **After lumbar puncture, the patient experiences shock. What is the etiology behind it?**

- a) Increased ICP.
- b) Headache.
- c) Side effect of medications.
- d) **CSF leakage**

1009. **Which is not an expected side effect of lumbar tap?**

- a) **Headache**
- b) Back pain
- c) Swelling and bruising
- d) **Nausea and vomiting**

1010. **A patient was recommended to undergo lumbar puncture. As the nurse caring for this patient, what should you not expect as its complications:**

- A. Swelling and bruising
- B. Headache
- C. Back pain
- D. **Infection**

1011. **A client immediately following LP developed deterioration of consciousness, bradycardia, increased systolic BP. What is this:**

- a) normal reaction
- b) **client has brain stem herniation**
- c) spinal headache

1012. **Mrs. A is posted for CT scan. Patient is afraid cancer will reveal during her scan. She asks "why is this test". What will be your response as a nurse?**

- a) Tell her that you will arrange a meeting with a doctor after the procedure
- b) Give a health education on cancer prevention
- c) Ignore her question and take her for the procedure
- d) **Understand her feelings and tell the patient that it is normal procedure.**

1013. **Severe bleeding is best characterised by:**

- A. moist skin and pinkish nailbeds
- B. dry skin and pinkish nailbeds
- C. **moist skin and bluish nailbeds**
- D. dry skin and bluish nailbeds

1014. **Which of the following would be an appropriate strategy in reorienting a confused patient to where her room is?**

- a) Place picture of her family on the bedside stand
- b) Put her name in a large letter on her forehead
- c) **Remind the patient where her room is**
- d) Let the other residents know where the patient's room is

1015. **MRSA means**

- A. Methilinase – Resistant Streptococcus Aureus
- B. Methicillin-Resistant Streptococcus Aureus
- C. Methilinase – Resistant Staphylococcus Aureus
- D. **Methicillin-Resistant Staphylococcus Aureus**

1016. **After lumbar puncture, the patient experiences shock. What is the etiology behind it?**



- A. Increased ICP.
- B. Headache.
- C. Side effect of medications

1017. **What is the preferred position for abdominal Paracentesis?**

- A. **Supine with head slightly elevated**
- B. Supine with knees bent
- C. Prone
- D. Side-lying

1018. **Correct position for abdominal paracentesis.**

- A. Lie the patient supine in bed with the head raised 45–50 cm with a backrest
- B. Sitting upright at 45 to 60
- C. Sitting upright at 60 to 75°
- D. Sitting upright at 75 to 90°

1019. A patient got admitted to hospital with a head injury. Within 15 minutes, GCS was assessed and it was found to be 15. After initial assessment, a nurse should monitor neurological status

- a) Every 15 minutes
- b) 30 minutes
- c) 40 minutes
- d) 60 minutes

1020. When a patient is being monitored in the PACU, how frequently should blood pressure, pulse and respiratory rate be recorded?

- A. Every 5 minutes
- B. Every 15 minutes
- C. Once an hour
- D. Continuously

1021. You walk onto one of the bay on your ward and noticed a colleague wrongly using a hoist in transferring their patient. As a nurse you will:

- A. let them continue with their work as you are not in charge of that bay
- B. report the event to the unit manager
- C. call the manual handling specialist nurse for training
- D. inform the relatives of the mistake

1022. A patient is being discharged from the hospital after having coronary artery bypass graft (CABG). Which level of the health care system will best serve the needs of this patient at this point?

- e) Primary care
- f) Secondary care
- g) Tertiary care
- h) Public health care

1023. Nurses are not using a hoist to transfer patient. They said it was not well maintained. What would you do?

- A. make a written report
- B. complain verbally
- C. take a picture for evidence
- D. Do nothing

1024. What is primary care?

- a) The accident and emergency room
- b) GP practices, dental practices, community pharmacies and high street optometrists
- c) First aid provided on the street

1025. What are the most common effect of inactivity?

- a) Social isolation, loss of independence, exacerbation of symptoms, rapid loss of strength in lg muscles, de-conditioning of cardiovascular system leading to an increased risk of chest infection and pulmonary embolism
- b) Loss of weight, frustration and deep vein thrombosis
- c) Deep arterial thrombosis, respiratory infection, fear of movement, loss of consciousness, de-conditioning of cardiovascular system leading to an increased risk of angina
- d) Pulmonary embolism, UTI, & fear of people

1026. Which strategy could the nurse use to avoid disparity in health care delivery?

- a) Campaign for fixed nurse-patient ratios.
- b) Care for more patients even if quality suffers
- c) Request more health plan options
- d) Recognize the cultural issue related to patient care.

1027. Why are physiological scoring systems or early warning scoring system used in clinical practice?

- a) These scoring systems are carried out as part of a national audit so we know how sick patients are in the united kingdom
- b) They enable nurses to call for assistance from the outreach team or the doctors via an electronic communication system
- c) They help the nursing staff to accurately predict patient dependency on a shift by shift basis
- d) The system provides an early accurate predictor of deterioration by identifying physiological criteria that alert the nursing staff to a patient at risk

1028. How can risks be reduced in the healthcare setting?

- a) By adopting a culture of openness & transparency & exploring the root causes of patient safety incidents.
- b) Healthcare will always involve risks so incidents will always occur .we need to accept this
- c) Healthcare professionals should be encouraged to fill in incident forms ; this will create a culture of “no blame”
- d) By setting targets which measure quality

1029. How can risk be reduced in the healthcare setting?

- A) By setting targets which measure quality
- B) Healthcare professionals should be encouraged to fill in incident forms; this will create a culture of "no blame"
- C) Healthcare will always involve risks so incidents will always occur, we need to accept this
- D) By adopting a culture of openness & transparency & exploring the root causes of patient safety incidents.**

**1030. You are caring for a patient who has had a recent head injury and you have been asked to carry out neurological observations every 15 minutes. You assess and find that his pupils are unequal and one is not reactive to light. You are no longer able to rouse him. What are your actions?**

- A. Continue with your neurological assessment, calculate your Glasgow Coma Scale (GCS) and document clearly.
- B. This is a medical emergency. Basic airway, breathing and circulation should be attended to urgently and senior help should be sought.**
- C. Refer to the neurology team.
- D. Break down the patient's Glasgow Coma Scale as follows: best verbal response V = XX, best motor response M = XX and eye opening E = XX. Use this when you hand over.

**1031. You believe that an adult you know and support has been a victim of physical abuse that might be considered a criminal offence. What should you do to support the police in an investigation?**

- a) Question the adult thoroughly to get as much information as possible
- b) Take photographs of any signs of abuse or other potential evidence before cleaning up the victim or the crime scene
- c) Explain to the victim that you cannot speak to them unless a police officer is present
- d) Make an accurate record of what the person has said to you**

**1032. If you witness or suspect there is a risk to the safety of people in your care and you consider that there is an immediate risk of harm, you should:**

- a) Report your concerns immediately, in writing to the appropriate person – Escalating concerns NMC
- b) Ask for advice from your professional body if unsure on what actions to take
- c) Protect client confidentiality
- d) Refer to your employer's whistleblowing policy
- e) Keep an accurate record of your concerns and action taken
- f) All of the above**

**1033. Which of the following is not a component of end of life care?**

- a) resuscitation and defibrillation**
- b) reduce pain
- c) maintain dignity
- d) provide family support

1034. Which of the following senses is to fade last when a person dies?

- a) hearing
- b) smelling
- c) seeing
- d) speaking

1035. The nurse is discussing problem-solving strategies with a client who recently experienced the death of a family member and the loss of a full-time job. The client says to the nurse. 'I hear what you're saying to me, but it just isn't making any sense to me. I can't think straight now.' The client is expressing feelings of:

- a) Rejection
- b) Overload
- c) Disqualification
- d) Hostility

1036. A newly diagnosed patient with Cancer says "I hate Cancer, why did God give it to me". Which stage of grief process is this?

- a) Denial
- b) Anger
- c) Bargaining
- d) Depression

1037. After death, who can legally give permission for a patient's body to be donated to medical science?

- a) Only the patient, if they left instructions for this
- b) The patient's spouse or next-of-kin
- c) The patient's GP
- d) The doctor in charge at the time of death

1038. Sue's passed away. Sue handled this death by crying and withdrawing from friend and family. As A nurse you would notice that sue's intensified grief is most likely a sign of which type of grief?

- a) Distorted or exaggerated Grief
- b) Anticipatory Grief
- c) Chronic or Prolonged Grief
- d) Delayed or Inhibited Grief

1039. Missy is 23 years old and looking forward to being married the following day. Missy's mother feels happy that her daughter is starting a new phase in her life but is feeling a little bit sad as well. When talking to Missy's mother you would explain this feeling to her as a sign of what?

- a) Anticipated Grief

- b) Lifestyle Loss
- c) Situational Loss
- d) **Maturational Loss**
- e) Self Loss
- f) All of the above

1040. A newly diagnosed patient with Cancer says "I hate Cancer, why did God give it to me". Which stage of grief process is this?

- a) Denial
- b) Bargaining
- c) Depression
- d) **Anger**

1041. A client is diagnosed with cancer and is told by surgery followed by chemotherapy will be necessary, the client states to the nurse, "I have read a lot about complementary therapies. Do you think I should try it?". The nurse responds by making which most appropriate statement?

- a) It is a tendency to view one's own ways as best"
- b) You need to ask your physician about it"
- c) I would try anything that I could if I had cancer
- d) **There are many different forms of complementary therapies, let's talk about these therapies**

1042. After the death of a 46 year old male client, the nurse approaches the family to discuss organ donation options. The family consents to organ donation and the nurse begins to process. Which of the following would be most helpful to the grieving family during this difficult time?

- a) Calling the client, a donor
- b) **Provide care to the deceased client in a careful and loving way**
- c) Encourage the family to make a quick decision
- d) Tell them that there is no time to all other family members for advice

1043. A critically ill client asks the nurse to help him die. Which of the following would be an appropriate response for the nurse to give this client?

- a) **Tel me why you feel death is your only option**
- b) How would you like to do this
- c) Everyone dies sooner or later
- d) Assisted suicide is illegal in this state

1044. A 42 year old female has been widowed for 3 years yet she becomes very anxious, sad, and tearful on a specific day in June. Which of the following is this widow experiencing?

- a) Preparatory depression
- b) Psychological isolation

- c) Acceptance
  - d) **Anniversary reaction**
1045. **The 4 year old son of a deceased male is asking questions about his father. Which of the following activities would be beneficial for this young child to participate in?**
- a) Nothing because he too young to understand death
  - b) Tell him his father has gone away, never to return
  - c) Tell him his father is sleeping
  - d) **Explain that his father has died and give him the option of attending the funeral**
1046. **The hospice nurse has been working for two weeks without a day off. During this time, she has been present at the deaths of seven of her clients. Which of the following might be beneficial for this nurse?**
- a) Nothing
  - b) Provide her with an assistant
  - c) **Suggest she take a few days off**
  - d) Assign her to clients that aren't going to die for awhile
1047. **The wife of a recently deceased male is contacting individuals to inform them of her husband's death. She decides, however, to drive to her parent's home to tell them in person instead of using the telephone. Of what benefit did this communication approach serve?**
- a) She needed to get out of the house
  - b) **For the family to gain support from each other**
  - c) No benefit
  - d) She was having a pathological grief response
1048. **While providing care to a terminally ill client, the nurse is asked questions about death. Which of the following would be beneficial to support the client's spiritual needs?**
- a) Nothing
  - b) Ask if they want to die
  - c) Ask if they want anything special before they die
  - d) **Provide support, compassion, and love**
1049. **A fully alert & competent 89 year old client is in end stage liver disease. The client says , "I'm ready to die," & refuses to take food or fluids . The family urges the client to allow the nurse to insert a feeding tube. What is the nurse's moral responsibility?**
- A) The nurse should obtain an order for a feeding tube
  - B) The nurse should encourage the client to reconsider the decision
  - C) **The nurse should honour client's decision**
  - D) The nurse must consider that the hospital can be sued if she honours the client's request

1050. A newly diagnosed patient with Cancer says "I hate Cancer, why did God give it to me". Which stage of grief process is this?

- a) Denial
- b) Anger
- c) Bargaining
- d) Depression

1051. A client is diagnosed with cancer what is your response?

- a) Take her to another room and allow her to discuss with the husband
- b) Tell them to wait in the room and I will come and talk to u after my duty

1052. After death, who can legally give permission for a patient's body to be donated to medical science?

- a) Only the patient, if they left instructions for this
- b) The patient's spouse or next-of-kin
- c) The patient's GP
- d) The doctor in charge at the time of death

1053. A patient who refuses to believe a terminal diagnosis is exhibiting

- a) Regression
- b) Mourning
- c) Denial
- d) Rationalization

1054. Patient says, "I hate this cancer". Nurse understands which stage patient is in according to Kubler Ross stages of death?

- a) Anger
- b) Denial
- c) Depression
- d) Bargaining

1055. after breaking bad news of expected death to a relative over phone , she says thanks for letting us know and becomes silent. Which of the following statements made by nurse would be more empathetic

- a) Say I will ask the doctor to call you
- b) You seem stunned. You want me to help you think what you want to do next
- c) Call me back if you have got any questions
- d) Say can I help you with funeral arrangements

1056. The nurse cares for a client diagnosed with conversion reaction. The nurse identifies the client is utilizing which of the following defense mechanisms?

- a) Introjection
- b) Displacement
- c) Identification
- d) **Repression**

1057. A 52-year-old man is admitted to a hospital after sustaining a severe head injury in an automobile accident. When the patient dies, the nurse observes the patient's wife comforting other family members. Which of the following interpretations of this behavior is MOST justifiable?

- A) She has already moved through the stages of the grieving process.
- B) She is repressing anger related to her husband's death.
- C) **She is experiencing shock and disbelief related to her husband's death.**
- D) She is demonstrating resolution of her husband's death.

1058. A slow and progressive disease with no definite cure, only symptomatic Management?

- a) Acute
- b) Chronic
- c) **Terminal**

1059. What is not included in Palliative Care?

- a) Psychological support
- b) Spiritual support
- c) **Resuscitation**
- d) Pain management

1060. What is the main aim of the End of Life Care Strategy (DH 2008)?

- a) **Identify a patient's preferred place of care**
- b) **An assessment is used to identify how and where patients wish to be cared for at the end of life**

